

174X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07275		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07271			
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year		2b. HOUR	
Helen McCollough Allard						MAY 21 1969		10:40 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		Sept. 17, 1902		66 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
New York		U.S.A.				Prince George			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
College Park		6300 Tecumseh Pl.		Teller		Bank			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
New York		Voorheesville						5 Forest Road	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
John McCollough		Mary Hill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		093 18 6655		Mrs. Joan Weisgerber		Same as #10 & 11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> 174X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos. 34 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb, 1969, to 5/21, 1969, that (I) (we) last saw the deceased alive on 5/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
G. Lennard Gold						5/21/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS					
G. Lennard Gold		9801 Ga. Ave., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 24, 1969		St. Agnes		Albany N. Y.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Francis J. Collins		MAY 23 1969		[Signature]					
500 University Blvd. Silver Spring, Md.									

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RECEIVED OF DEATH

RECEIVED OF DEATH

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07276

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07273

FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR 1:10 p M	
Joseph		GID		Alvarez				5-29		19 69	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
M	W	12-18-1910		58 YRS.						5 29 19 69	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
FLORIDA		USA									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
RIVERDALE				LELAND MEMORIAL HOSP				FORD AUTO MECHANIC			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Howard		Laurel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1409 Scaggsville Rd.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
unknown				unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
yes				1919-1961		Joseph A Alvarez - abame					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.	
4123										Heart failure	
										Arteriosclerotic heart disease	
										unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				5-3069			
John Kehoe, M.D., Riverdale				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS(Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				6/3/69		Arlington National		Arlington Va.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Dandredan Funeral Home				Laurel				JUN 5 1969		J. Carlos Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FLORIDA, U.S.A.

REKAP: LEAD MEMORIAL FOR MICHAE

Joseph's Library - 100

of the 1st

Print 6/1/83
Print 6/1/83

8-1
4309
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
07277					07274							
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Helen P. Arey					2a. DATE OF DEATH Month Day Year May 30 1969			2b. HOUR 10:15 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-17-13			6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Librarian			12b. KIND OF BUSINESS OR INDUSTRY Library				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY P. G.		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6164 Springhill Terrace				
14. FATHER'S NAME First Middle Last James I. Pyle					15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Weaver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 167 14 0484		17. INFORMANT 107 White Birch Court Wesley A. Sweat Jr. Greenbelt, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Embolism</u> 4309 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Ruptured Berryaneurism</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1969</u> , to <u>May 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Till Bergemann</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) Till Bergemann M.D.					22e. ADDRESS Professional Building Centenary Greenbelt							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/4/69		23c. NAME OF CEMETERY OR CREMATORY Lancaster Cemetery			23d. LOCATION (City and town) (County) (State) Lancaster Pa.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR JUN 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07278		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07275	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
WILLIAM HENRY ATKINSON						MAY 4 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
MALE		CAUCASIAN		12 DEC 1897		71 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MISS.		U.S.				PRINCE GEORGES Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
GREENBELT		10-C HILLSIDE RD		DRAFTSMAN		U.S. GOVT.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		PRINCE GEORGES		GREENBELT		10-CHILLSIDE ROAD	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
UNKNOWN						UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		427-26-1477		MARY E. ATKINSON		SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CARCINOMA OF LARYNX							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 4 MAY 1969, that (we) last saw the deceased alive on 10 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur Kaufman, M.D.				22c. DATE SIGNED		22d. ADDRESS	
22e. PHYSICIAN'S NAME (Type)				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL				5-7-1969		FORT LINCOLN CEM	
23d. LOCATION (City or Town) (County) (State)				23e. REC'D BY REGISTRAR			
COLMAR MANOR, MARYLAND				MAY 8 1969			
24. FUNERAL DIRECTOR W.W. CHAMBERS Co, RIVERDALE, MD.				25b. REGISTRAR'S SIGNATURE William Judge			

87278

WILLIAM HENRY ATKINSON

GRANVILLE 12 DEC 1917

THREE POUNDS

W 22

STENNETT

10-6 BLISSING RD

LESTERSMAN

W 2 20

ANYTHING TO BE SENT TO THE POST OFFICE

W 2 20

LESTERSMAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07279

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07276

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Mabel E. Bacigaluppi						5/11/69 Month Day Year			5:40AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
F		W		7/13/1887			81 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Prince Georges Co.		USA					Prince Georges County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Georges Hospital			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD			PG			District Hghts.		YES <input type="checkbox"/> NO <input type="checkbox"/>		7306 Gateway Boulevard	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Benjamin F. Richardson						Georgia A. Pope					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
no			-			Joseph Bacigaluppi, Son 9103 Sheridan Ct., Sea Brook, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASHD with Myocardial Infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>plus Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-3</u> , 19 <u>67</u> , to <u>May 11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 11</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
John F. Hay			5-12-69			5509 Old Silver Hill Rd. Suitland, Md.					
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			5/14/69		Washington National			Suitland, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home 4308 Suitland Rd., S.E., Suitland, Md., 20023						MAY 15 1969		[Signature]			

03238

DEPARTMENT OF HEALTH

LABORATORY OF VIRUS RESEARCH, 1400 EAST 17TH AVENUE, DENVER, COLORADO

REPORT OF INVESTIGATION

NO. 1

IN THE CITY OF DENVER, COLORADO

ON THE 10th DAY OF MAY, 1954

BY DR. J. H. HAY, JR., DIRECTOR

AND DR. J. H. HAY, JR., ASSISTANT

TO THE BOARD OF HEALTH OF THE CITY OF DENVER

RE: INVESTIGATION OF THE CAUSE OF

THE OUTBREAK OF POLIO IN DENVER

IN THE YEAR 1953

AND THE RESULTS OF THE INVESTIGATION

CONDUCTED BY THE LABORATORY OF VIRUS RESEARCH

OF THE DEPARTMENT OF HEALTH

OF THE CITY OF DENVER

AND THE RESULTS OF THE INVESTIGATION

CONDUCTED BY THE LABORATORY OF VIRUS RESEARCH

OF THE DEPARTMENT OF HEALTH

OF THE CITY OF DENVER

AND THE RESULTS OF THE INVESTIGATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07280

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07277

1. DECEASED-NAME (Type or Print)		First	Middle	Last	20. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
Clarence		Walter	Bailey		5		3	19	69	6:20
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost (Specify))	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		2c. DATE PRONOUNCED DEAD Month	
M	W	23 July 1895		73 YRS.					5 Day 3 Year 1969	
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Conn.		U. S. A.				Prince George		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George Hosp		Ret. Painter		Construction				
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md		Prince George Forestville		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				7325 Cross Street		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Charles		F.	Bailey		Fannie				Braze	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		WW 1		223 10 4882		Clara E. Bailey Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Multiple rib fractures										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:45 PM 4 27 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) Passenger in car which overturned.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
				St Rt 4, near Woodyard Rd.		P.G.				Md.
220. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-3-69
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATION		23d. LOCATION (City or Town)		(County)		(State)
Burial		5/7/69		Calvary Meth. Church		Stuarts Draft		Augusta		Va.
24. FUNERAL DIRECTOR		ADDRESS		250. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Francis Gasch's Sons		Hyattsville, Md.		MAY 7 1969		Charles Judge				

07280

2--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (3)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Norma M. Baker			2a. DATE OF DEATH May Month 5 Day 1969 Year			2b. HOUR 12:52 P.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 05-01-1927		6. AGE (In years last birthday) 42 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gne. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY Prince George's		13c. CITY OR TOWN Hillside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1103 57th Ave.	
14. FATHER'S NAME First Middle Last Louis			15. MOTHER'S MAIDEN NAME First Middle Last Bernice Lang						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT Roy Baker		Address Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Stem hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 3, 1969, to May 5, 1969, that (I) (we) last saw the deceased alive on May 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P.C. Xavier, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 5, 1969			
22d. PHYSICIAN'S NAME (Type) P.C. Xavier, M.D.				22e. ADDRESS Prince George's Gen. Hosp.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/8/69		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Md			
24. FUNERAL DIRECTOR Scarpelli Funeral Home Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Doris Lucille Bartholemew						Month Day Year May 8 1969			5:05PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White		10-25-10			58 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Iowa		U.S.A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George's Gen. Hosp.		Ret. Secretary		G.C.S.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		Prince George's		Greenbelt		YES		2 A Eastway Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Thomas C. Olds			Belle Simpson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
no					Thomas R. Bartholomew Bowie, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage; left</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) <u>Metastatic CA to liver and peritoneum</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> , 19 <u>65</u> , to <u>May 8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		HANS WODATK M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								5-9-1969	
22d. PHYSICIAN'S NAME (Type)		HANS WODATK M.D.		22e. ADDRESS		GREENBELT, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/12/69		Oakland Cemetery		Centerville Appanoose Iowa			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Basch's Sons				Hyattsville, Md		MAY 13 1969		William J. Jones	

415

112

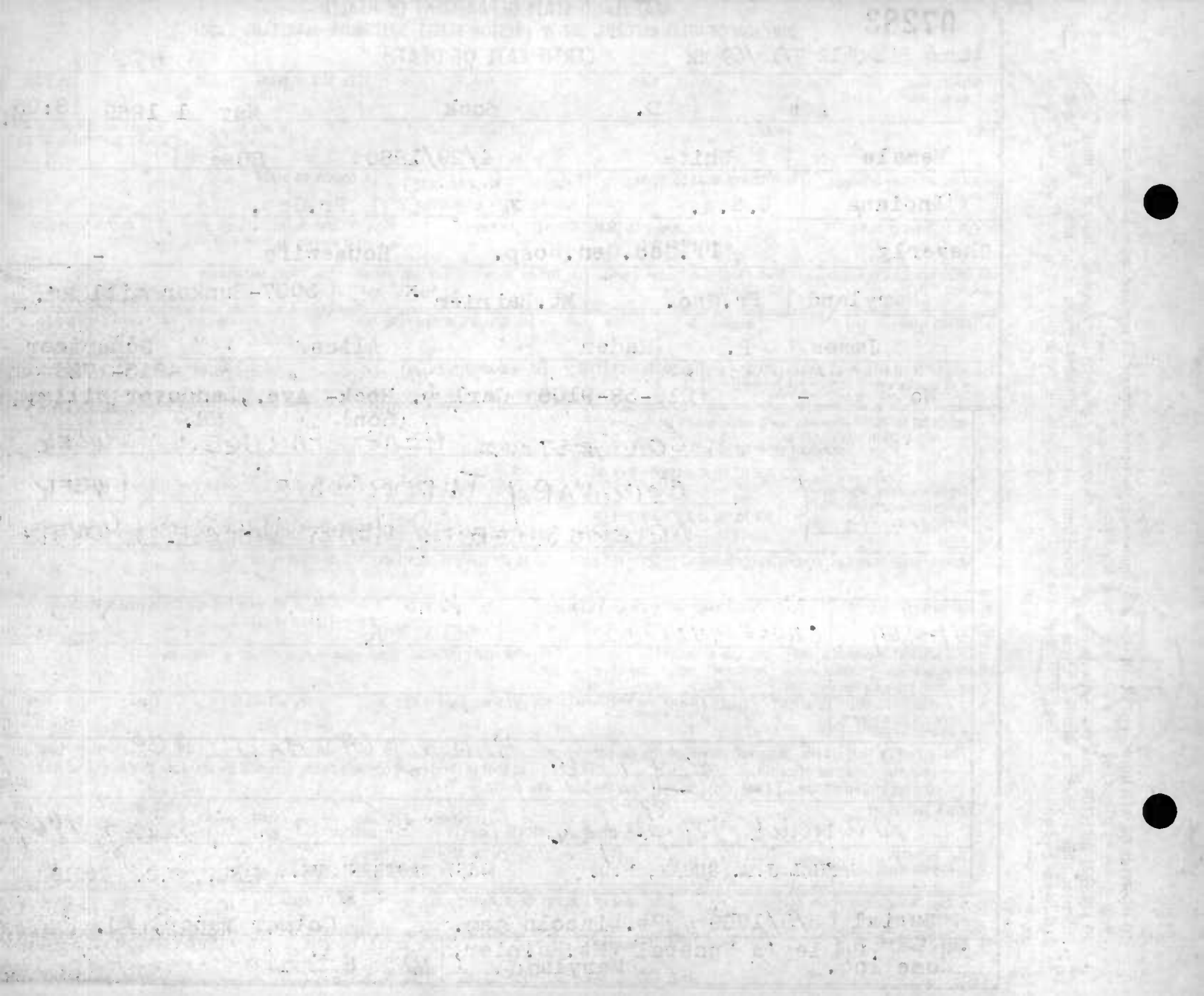
• 5 1 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

07283		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07280	
Item 6 Film 412 5/12/69 kk		CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
Ada		D.	Bock	May 1 1969	8:05 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		White		4/29/1880		88 89 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Indiana		U.S.A.		Pr. Geo.		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Pr. Geo. Gen. Hosp.		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Pr. Geo.		Mt. Rainier		3007-Bunker Hill Rd.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
James		P.	Rader	Alice	Schertzer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		218-38-9106		Carl L. Bock- Ave., Landover Hills.		4213- 72d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF (b)		21. DUE TO, OR AS A CONSEQUENCE OF (c)	
4109		CONGESTIVE HEART FAILURE		CORONARY THROMBOSIS		ARTERIO SCLEROTIC HEARTS DISEASE	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4/4/69		CHOLECYSTITIS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from		MAY 21, 19 69, to		MAY 1, 19 69, that (I) (we) saw the deceased alive on		MAY 1, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
SAMUEL J.N. SUGAR, M.D.						MAY 2, 1969	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DATE			
SAMUEL J.N. SUGAR, M.D.		4637 EASTERN AVE., WASH., D.C. 20018		MAY 6 1969			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/5/1969		Ft. Lincoln Cem.		Colmar Manor, Md.	
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Nalley's Funeral Home Inc.		Mt. Rainier, Maryland		MAY 6 1969		Charles Judge	



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>ARTH</i> <i>Hannah</i> <i>Bond</i>					2a. DATE OF DEATH Month Day Year <i>5</i> <i>9</i> <i>69</i>			2b. HOUR <i>10:55 A M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-6-1883</i>		6. AGE (In years last birthday) <i>86</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>VA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.			
10. CITY OR TOWN OF DEATH <i>Clinton, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pineview Gardens</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Pr. Geo's</i>		13c. CITY OR TOWN <i>Brandywine</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 103 Dryson Road</i>	
14. FATHER'S NAME First Middle Last <i>John</i> <i>Goode</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Theresa</i> <i>Butts</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>James Bond- BKKKX</i>		Address <i>Brandywine, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i>	
4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary embolism</i>								<i>1 min.</i>	
(c) <i>Coronary heart disease</i>								<i>12 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerosis Cardiovascular disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>6-11</i> , 19 <i>68</i> , to <i>5/9</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/8</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alfred R. Lapin M.D.</i>					DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 9, 1969</i>
22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN M.D.</i>					22e. ADDRESS <i>CLINTON, MD</i>				
23a. BURIAL-CREMATORY <i>Burial</i>		23b. DATE <i>5/13/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Pr. Geo's Md.</i>			
24. FUNERAL DIRECTOR <i>Ritchie Bros. Upper Marlboro, Md. 20870</i>					25a. REC'D BY REGISTRAR DATE <i>MAY 13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

07222

annex

Grand House

BRIDGE

James Bond - MINNICK

NO

Collection of...
Various...
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...
...
...

5/1/59 Cedar Hill Cemetery
Burlington, VT 05401
James Bond, Upper Marlboro, MD 20670

07285

CERTIFICATE OF DEATH

07282

1. DECEASED-NAME (Type or print)		First Aristide	Middle L.	Last Borelli	2a. DATE OF DEATH Month Day Year May 10, 1969		2b. HOUR 4:40AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9/8/92		6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George's Md.				
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stone Mason		12b. KIND OF BUSINESS OR INDUSTRY US Gov't		
13a. USUAL RESIDENCE (Where deceased admission) STATE District of Col.	13b. CITY OR TOWN Dist. Of Columbia	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3529 Highwood Drive, S.E.				
14. FATHER'S NAME First Middle Last Giacchino - Borelli	15. MOTHER'S MAIDEN NAME First Middle Last Francesca - Palmieri						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT Francis Borelli 11011 Bennington Dr Upper Marlboro					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Emphysema, Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Bronchitis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) this hospital attended the deceased from <u>3-5</u> , 19 <u>62</u> , to <u>May 10</u> , 19 <u>69</u> , that (I) we lost saw the deceased alive on <u>5-9</u> , 19 <u>69</u> , and that in (my) their opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. Kemal Mutlu M.D.</u>		22c. DATE SIGNED May 10, 1969		22d. PHYSICIAN'S NAME (Type) M. Kemal Mutlu, M.D.			
22e. ADDRESS 4900 Silver Hill Rd., Suitland, Md. 20023							
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 13, 1969	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town)		(County)	(State)
Burial				Bladensburg		Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR DATE MAY 14 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1850

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07286

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07283

1. DECEASED-NAME (Type or Print)		First Stanley	Middle Howard	Last Bossert	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5 21 1969		2b. HOUR 4:26 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH 26 Aug., 1954		6. AGE (In years lost birthday) 14 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign (country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges		2d. HOUR 4:26 AM
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince George Bowie		13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12418 Sandal Lane	
14. FATHER'S NAME First Middle Last John Lewis Bossert		15. MOTHER'S MAIDEN NAME First Middle Last Lucretia - Vincent		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ---			
16b. SOCIAL SECURITY NO. None		17. INFORMANT John L. Bossert, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1709 Metastatic sarcoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Ewings sarcoma DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 5 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kenoe, M.D.,		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Prince Georges Co.		22b. DATE SIGNED 5 21 69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/23/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons 5130 Wisconsin Ave., N.W. Washington, D. C.				25a. REC'D BY REGISTRAR DATE MAY 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

07288

THE NATIONAL ARCHIVES
COLLEGE PARK, MARYLAND

1944

100

John A. Bennett, born 1911

John A. Bennett, born 1911

Prince George's Co.

1944

MAY 2 1944

7778
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07287

CERTIFICATE OF DEATH

07284

1. DECEASED-NAME (Type or print)		First Baby	Middle Girl	Last Bosworth	2a. DATE OF DEATH Month May		Day 17,	Year 1969	2b. HOUR 2:00P M		
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH May 17, 1969		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN 5 10
7a. BIRTHPLACE (State or foreign country) Prince George's		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ---		12b. KIND OF BUSINESS OR INDUSTRY ---					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7210 Chesapeake St.			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 7778 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (A) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>69</u> , to <u>May 17</u> , 19 <u>69</u> , that (X) (we) lost saw the deceased alive on <u>May 17</u> , 19 <u>69</u> , and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <u>Hugh Clark</u>		22c. DATE SIGNED <u>May 18 1969</u>			22d. PHYSICIAN'S NAME (Type) Dr. Hugh Clark						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5-24-69		23c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		23d. LOCATION (City or Town) Cheverly, Prince George's, Md.		(County)		(State)	
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr.</u> Harry W. Penn, Jr., Administrator		25a. REC'D BY REGISTRAR DATE MAY 28 1969			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

07583



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>07288</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>07285</div>											
<div>Item 5 Film 412 5/12/69 kk</div> <div>CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) First FRANK Middle JOSEPH Last BOURELL						2a. DATE OF DEATH Month 5 Day 3 Year 1969			2b. HOUR 2:40 M		
3. SEX MALE		4. RACE W		5. DATE OF BIRTH 3/29/1890		6. AGE (In years lost birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS 79 DAYS 79		IF UNDER 24 HRS. HOURS 79 MIN.	
7a. BIRTHPLACE (State or foreign country) MASS.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Bldg.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MASS.		13b. CITY OR TOWN P.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5501 Parkland Ct. S.E.					
14. FATHER'S NAME First FRANK Middle BOURELL Last Unknown				15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 577-24-9130		17. INFORMANT Address A Vincent Cook, Step-Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4123 CARDIAC ARREST.										FEW MINUTES.	
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE										3 DAYS.	
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC HEART DISEASE										FEW YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CEREBRAL VASCULAR ACCIDENT											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 5 Day 6 Year 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 11 Miss Ave. S.E. WASHINGTON DC		City or Town Suitland, Maryland		County Prince George		State Md.	
22a. I certify that (I) (this hospital) attended the deceased from 7-16-68 , 19 68 , to 5-3 , 19 69 , that (I) (we) last saw the deceased alive on 5-3 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Mostaan, M.D.						DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-3-69			
22d. PHYSICIAN'S NAME (Type) REZA MOSTAAN, M.D.				22e. ADDRESS 11 Miss Ave. S.E. WASHINGTON DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/6/69		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) Suitland, Maryland		(County) Prince George		(State) Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home				ADDRESS 2308 Suitland Rd., S.E., Suitland, Md., 20023		25a. REC'D BY REGISTRAR MAY 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03882

THEORY OF PLASMA

10461968

10461968

10461968

07289

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ANNA			First Middle Last K. BRAASCH			2a. DATE OF DEATH Month 20 Day 19 Year 1969			2b. HOUR 3:00 PM		
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH 2-21-98			6. AGE (In years lost birthday) 71 YRS.		
7a. BIRTHPLACE (State or foreign country) New Jersey			7b. CITIZEN OF WHAT COUNTRY? U.S. A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH PRINCE GEORGE Md		
10. CITY OR TOWN OF DEATH Forestville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Prince George District			13c. CITY OR TOWN Forestville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last William H. Karrer			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Hughes			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) yes WW I			16b. SOCIAL SECURITY NO.		
17. INFORMANT George H. Braasch			17. ADDRESS 12340 Chalmers Drive Battle Creek, Mich.			18. PHONE 49017			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) High fever, severe pneumonia, Central thrombosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-2-69 , to 5-20-69 , that (I) (we) last saw the deceased alive on 5-19-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Oliver B. Bond						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED MAY 20-1969		
22d. PHYSICIAN'S NAME (Type) OLIVER B. BOND						22e. ADDRESS 7420 MARLBORO PIKE FORESTVILLE MD 20028					
23a. BURIAL, CREMATION, OR OTHER DISPOSITION INTERMENT			23b. DATE May 23-69			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Simmons Bros						ADDRESS 1661-Gd. Hope Rd. SE Wash., DC			25a. REC'D BY REGISTRAR MAY 23 1969		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03580

Handwritten notes at the top of the page, including the word "Hence" and "12 miles" followed by some illegible scribbles.

Main body of handwritten notes on lined paper. The text is mostly illegible due to fading and bleed-through. Some legible fragments include "12 miles", "Hence", and "12 miles" again further down. There are several lines of cursive writing throughout the page.

4124
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07290									
CERTIFICATE OF DEATH									
07287									
1. DECEASED-NAME (Type or print) Angeline E Bradshaw					2a. DATE OF DEATH Month May Day 20 Year 1969			2b. HOUR 9:20 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 20, 1877		6. AGE (In years lost birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) District of Columbia United States		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 1226 Saratoga Ave., N.E.			
14. FATHER'S NAME John Richard Phillips		15. MOTHER'S MAIDEN NAME Agnes Ebert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-30-3557		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Fibullectus DUE TO, OR AS A CONSEQUENCE OF (c) Senescent Arteriosclerotic Cardio-Vascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 year 5 year 15 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 65 , to 5-20 , 19 69 , that (I) (we) last saw the deceased alive on 5-1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE O. SAHAKIAN		22c. DATE SIGNED 5-20-69		22d. ADDRESS 6001 Landover Rd. Chevy Chase					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 5/23/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) (County) (State) Wash., D.C.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

07390

REVENUE OF DEATH

Name of Deceased		Age		Sex		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death	
John Doe		45		Male		Married		Farmer		Heart Disease		Jan 15, 1920		Farm, Iowa	
Name of Beneficiary		Age		Sex		Marital Status		Occupation		Relationship to Deceased		Date of Birth		Place of Birth	
Jane Doe		42		Female		Married		Homemaker		Wife		Jan 10, 1918		Farm, Iowa	
Name of Executor		Age		Sex		Marital Status		Occupation		Relationship to Deceased		Date of Birth		Place of Birth	
John Doe		45		Male		Married		Farmer		Son		Jan 15, 1920		Farm, Iowa	
Name of Administrator		Age		Sex		Marital Status		Occupation		Relationship to Deceased		Date of Birth		Place of Birth	
Jane Doe		42		Female		Married		Homemaker		Daughter		Jan 10, 1918		Farm, Iowa	
Name of Creditor		Age		Sex		Marital Status		Occupation		Relationship to Deceased		Date of Birth		Place of Birth	
John Doe		45		Male		Married		Farmer		Son		Jan 15, 1920		Farm, Iowa	
Name of Debtor		Age		Sex		Marital Status		Occupation		Relationship to Deceased		Date of Birth		Place of Birth	
Jane Doe		42		Female		Married		Homemaker		Daughter		Jan 10, 1918		Farm, Iowa	

John Doe
Executor

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <i>Paula L. Brann</i>					2a. DATE OF DEATH Month Day Year <i>May 2 1969</i>					2b. HOUR <i>7:55 A.M.</i>
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>July 11, 1891</i>		6. AGE (in years last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Berlin, Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i> Md.				
10. CITY OR TOWN OF DEATH <i>Forestville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Regent Nursing Home</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>N.Y.</i>			13b. COUNTY <i>Bay Ridge</i>		13c. CITY OR TOWN <i>Bay Ridge</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>702-44th St.</i>	
14. FATHER'S NAME First Middle Last <i>Edgar unknown</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Toni Sklarz</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Eva Toni Brann, Daughter 217 Hanover St., Annapolis, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma Rt. Lung</i>										<i>1 yr</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma Rt. Breast.</i>										<i>9 yrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Parkinsons disease</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 5, 1967</i> , to <i>May 2, 1969</i> , that (I) (we) last saw the deceased alive on <i>Apr. 28, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Walter B. Sheer M.D.</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 2, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>WALTER B. SHEER</i>					22e. ADDRESS <i>6400 MARLBORO PIKE S.E. WASH. DC.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5/5/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Knolwood Park Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>New York City, New York</i>			
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm</i> Address <i>4308 Suitland Rd., S.E., Suitland, Md., 20023</i>					25a. REC'D BY REGISTRAR <i>MAY 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Lucille Middle Brent Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 5 Day 7 Year 1969			
3. SEX F	4. RACE Negro	5. DATE OF BIRTH # 3 Feb 1910	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month 5 Day 7 Year 1969	2d. HOUR 1:25 P.M.
7a. BIRTHPLACE (State or foreign country) N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Glendale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glendale Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE DC		13b. COUNTY Washington		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7135 8th St., N.W.	
14. FATHER'S NAME First Boyd Middle -- Last Oldham			15. MOTHER'S MAIDEN NAME First Mattie Middle -- Last Roberts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) unknown		17. INFORMANT Decedent		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure 890X DUE TO, OR AS A CONSEQUENCE OF and Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Burns-65-70% body surface DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 30 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertensive arteriosclerotic heart disease Recurrent CVA's yrs.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 7:24am 5-6-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Bed clothing caught fire from cigaret				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Glendale Hosp		21f. LOCATION Street or R.F.D. No. Glendale		City or Town Prince George		County Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe			EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-7-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/10/1969		23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Landover, Maryland			
24. FUNERAL DIRECTOR W. Ernest Jarvis Co., Inc.				ADDRESS 1432 You Street, N.W.		25a. REC'D BY REGISTRAR DATE MAY 12 1969		25b. REGISTRAR'S SIGNATURE W. Ernest Jarvis	

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MINIMUM REQUIREMENT ELEMENTS OF MARK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.)

07293

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07290

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Mary			First Brown			Middle			Last			2a. DATE OF DEATH May Month 4 Day Year 69			2b. HOUR 5:45a					
3. SEX N Female			4. RACE Negro			5. DATE OF BIRTH 09-09-14			6. AGE (In years last birthday) 54 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) S.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince Geo.											
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY PG			13c. CITY OR TOWN Chapel Oaks			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5906 Fairmont Gardens								
14. FATHER'S NAME Deceased			First Middle Last			15. MOTHER'S MAIDEN NAME Deceased			First Middle Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Glover C. Brown - 5904 - Boundary Ave.			Address Hillside, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4122 IMMEDIATE CAUSE (a) Hypertension, Cardiovascular disease with DUE TO, OR AS A CONSEQUENCE OF congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia Clinical DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from April 24 , 19 69 , to May 4 , 19 69 , that (I) (we) lost saw the deceased alive on May 4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED May 5, 1969											
22d. PHYSICIAN'S NAME (Type) S.V. Nair, M.D.			22e. ADDRESS Prince George's Gen. Hosp.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 5/10/69			23c. NAME OF CEMETERY OR CREMATORY HARMONY Mem. PARK			23d. LOCATION (City or Town) (County) (State) Highland Park Md											
24. FUNERAL DIRECTOR Henry S. Washington			ADDRESS 1225 Doris Ave			25a. REC'D BY REGISTRAR [Signature]			25b. REGISTRAR'S SIGNATURE [Signature]			DATE MAY 9 1969								

07293



[Handwritten signature]

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7769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Patrick John Brown					2a. DATE OF DEATH Month May Day 10 Year 1969			2b. HOUR 10:30A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 7, 1969		6. AGE (In years last birthday) YRS. 3		IF UNDER 1 YEAR MONTHS 3 DAYS 3	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5024 Townsend Way	
14. FATHER'S NAME First Kenneth Middle D. Last Brown		15. MOTHER'S MAIDEN NAME First Deborah Middle K. Last Adams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Kenneth D. Brown same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, 2200 grams 7769 DUE TO, OR AS A CONSEQUENCE OF (b) Atalectasis of Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ---								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 7 , 1969, to May 10 , 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 10 , 1969, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hugh G. Clark		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 10 1969					
22d. PHYSICIAN'S NAME (Type) Hugh G. Clark		22e. ADDRESS Prince George Gen. Hospital-Cheverly, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/12/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS H yattsville, Md.		25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45M - 1-69

07295		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07292	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First REBECCA	Middle	Lost BROWN	20. DATE OF DEATH Month MAY Day 13 Year 1969
3. SEX F	4. RACE C	5. DATE OF BIRTH 6-16-77		6. AGE (In years last birthday) 91 YRS.	2b. HOUR 4:45 A
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens Rehab Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dry worker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Pr. Gea	13c. CITY OR TOWN Brandywine	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Isiah Middle Brown Lost	15. MOTHER'S MAIDEN NAME First Louise Middle Jones Lost		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Gwendolyn Ford.		Address Gen'l Del. way Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) cardiovascular arteriosclerotic disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 2 Day 2 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2/29, 1968 , to 5/12, 1969 , that (I) (we) lost the deceased alive on 5/12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alfred R. Lapin		DEGREE ALFRED R. LAPIN	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/13/69	
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN		22e. ADDRESS CLINTON, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 17-69	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Garden Cem.		23d. LOCATION (City or Town) (County) (State) Clinton-Pr. Geo. Md.	
24. FUNERAL DIRECTOR Martell Adams		ADDRESS Aguasco, Md.		25a. REC'D BY REGISTRAR MAY 21 1969	25b. REGISTRAR'S SIGNATURE Johnnie Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07296		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07293	
Items 1 & 2		Film 413 6/3/69 kk		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) <u>Edgar</u> <u>Edgar</u>		20. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>69</u>		2b. HOUR <u>9:45</u> AM	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>11-10-80</u>	
6. AGE (In years last birthday) <u>88</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS. HOURS <u> </u> MIN <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Prince Georges co.</u>		Md.			
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince Georges Gen. Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) <u>Maryland</u>		13b. COUNTY <u>Prince Georges</u>		13c. CITY OR TOWN <u>Seat Pleasant</u>	
13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <u>419 69th Place</u>			
14. FATHER'S NAME First <u>Unknown</u> Middle <u> </u> Last <u> </u>		15. MOTHER'S MAIDEN NAME First <u>Hattie</u> Middle <u> </u> Last <u>Redding</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>578-03-0211</u>		17. INFORMANT Address <u>Bessie Browning Same as 13abcde</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA, RT-LUNG</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PULMONARY EMPHYSEMA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> , 19 <u>69</u> , to <u>5-25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Max M. Herzberg, M.D.</u> DEGREE <u> </u> ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. 22c. DATE SIGNED <u>5-26-1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Thomas MAX Herzberg</u>		22e. ADDRESS <u>3308 Dodge Park Road Landover, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/28/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Adair Hill</u>	
23d. LOCATION (City or Town) (County) (State) <u>Shiloh Park Burial</u>					
24. FUNERAL DIRECTOR <u>Mattingly 131-11th St. S.E. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	

04236

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C. 20535

DEPARTMENT OF JUSTICE

TO : DIRECTOR, FBI (100-371000) FROM : SAC, NEW YORK (100-100000) (P)

SUBJECT: [Illegible] (NY 100-100000) (P)

RE: [Illegible] (NY 100-100000) (P)

DATE: [Illegible] (NY 100-100000) (P)

BY: [Illegible] (NY 100-100000) (P)

FOR THE DIRECTOR: [Illegible] (NY 100-100000) (P)

FOR THE SAC: [Illegible] (NY 100-100000) (P)

FOR THE ASAC: [Illegible] (NY 100-100000) (P)

FOR THE CLERK: [Illegible] (NY 100-100000) (P)

FOR THE RECEPTIONIST: [Illegible] (NY 100-100000) (P)

FOR THE MAIL ROOM: [Illegible] (NY 100-100000) (P)

FOR THE TELETYPE UNIT: [Illegible] (NY 100-100000) (P)

FOR THE RECORDS SECTION: [Illegible] (NY 100-100000) (P)

FOR THE TRAINING SECTION: [Illegible] (NY 100-100000) (P)

FOR THE OFFICE OF THE CHIEF OF POLICE: [Illegible] (NY 100-100000) (P)

FOR THE OFFICE OF THE ATTORNEY GENERAL: [Illegible] (NY 100-100000) (P)

FOR THE OFFICE OF THE SECRETARY OF DEFENSE: [Illegible] (NY 100-100000) (P)

FOR THE OFFICE OF THE SECRETARY OF THE INTERIOR: [Illegible] (NY 100-100000) (P)

FOR THE OFFICE OF THE SECRETARY OF AGRICULTURE: [Illegible] (NY 100-100000) (P)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Inery E. Bryant</i>						2a. DATE OF DEATH <i>5</i> Month <i>7</i> Day <i>69</i> Year			2b. HOUR <i>3:50 PM</i>			
3. SEX <i>F</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>March 30, 1888</i>			6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i> Md.						
10. CITY OR TOWN OF DEATH <i>Clinton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Pine View Gardens</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales Lady</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Retail Store</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DC</i>				13b. COUNTY <i>136</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>915 Alabama Ave. SE</i>		
14. FATHER'S NAME First <i>John</i> Middle <i>Dungan</i> Last <i></i>				15. MOTHER'S MAIDEN NAME First <i>Rebecca</i> Middle <i>Winstone</i> Last <i>Head</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Jean Headley - 124 Robert St. SE Md</i> Address <i>Oxon Hill</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>4123 Cardiac Arrest</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction with Coronary Occlusion</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Reclusion</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis Cardiac and renal disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>March 21, 1969</i> , to <i>May 7, 1969</i> , that (I) (we) last saw the deceased alive on <i>3/7</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Alfred R. Lapina</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/7/69</i>								
22d. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPINA</i>		22e. ADDRESS <i>CLINTON, MD</i>										
23a. BURIAL CREMATION <i>REMOVED</i>		23b. DATE <i>May 10-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethany Church Cemetery - Callao, Virginia</i>		23d. LOCATION (City or Town) (County) (State)						
24. FUNERAL DIRECTOR <i>Simmons Brothers</i>		ADDRESS <i>Wash., D.C.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE						
DATE <i>MAY 9 1969</i>												

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1938

W. D. DOWD

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4309
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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07298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07295

1. DECEASED-NAME (Type or print) First Middle Last David Buckbinder		2a. DATE OF DEATH 5 Month 18 Day 69 Year		2b. HOUR 10 ^{PM}	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11-2-30	
7a. BIRTHPLACE (State or foreign country) PAWTUCKET, R.I.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) 38 YRS.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges		9. COUNTY OF DEATH Prince Georges Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY PG		12b. KIND OF BUSINESS OR INDUSTRY I.R.S.	
14. FATHER'S NAME First Middle Last Louis Buckbinder		15. MOTHER'S MAIDEN NAME First Middle Last Eda Gertrude Mizel		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GROUP SUPERINTENDENT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) NO		16b. SOCIAL SECURITY NO. KOREAN 038-18-4670		17. INFORMANT Address Eline Buckbinder 2804 Spind 1a	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4309 respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) cerebral edema DUE TO, OR AS A CONSEQUENCE OF (c) subarachnoid hemorrhage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ruth K. Jakoby		22c. DATE SIGNED 5-18-69		22d. PHYSICIAN'S NAME (Type) Ruth K. Jakoby	
22e. ADDRESS 6401 Landover Rd. Cheverly, Md.		22f. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		23b. DATE 5-20-69		23c. NAME OF CEMETERY OR CREMATORY LINCOLN PARK CEMETERY	
23d. LOCATION (City or Town) WARWICK, RHODE ISLAND		23e. REC'D BY REGISTRAR MAY 20 1969		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					

07293

DATE OF DEATH

WATKINS, J. I.

GROUP SETTLEMENT

1.1.2

038-13-1470

ROYAL

KEY

WATKINS, WHITE ISLAND

REMOVAL-SUBAL 1-20-49

201 LINCOLN & BROS., 2018 REISTERSTOWN ROAD

WATKINS, J. I.

6001 Lindover St. Channing, Va.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07299

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07296

1. DECEASED-NAME (Type or Print)		First		Middle		Last		20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 5-4-69		2b. HOUR 192:41am M					
Thomas						Burgess									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 5 4 69 193:10am M					
Male	Negro	4-4-1937		32 YRS.											
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md					
D. C.		U.S.A.				Prince George's									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Cheverly		Prince George Hospital		Electrician											
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER									
District Of Columbia		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		662 Jefferson St. N.E.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
Dock						Burgess									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
				Dock Burgess - 5909 7th Street, NW											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of right chest</u> 965x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:40am 5-4- 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot during altercation							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Glen Arden Town Hall, Glen Arden, Prince George's Co., Maryland				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 5-5-69							
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				5-9-69				Harmony Memorial Park				Prince George, Md			
24. FUNERAL DIRECTOR John T. Rhines Co. Funeral Home 3015 12th Street, N. E.								25a. REC'D BY REGISTRAR DATE MAY 8 1969				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07300

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07297

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
Kermit						Butler		OF ESTI- DEATH MATED <input type="checkbox"/> 5-28-69		1910: 30am	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
Male	Negro	12-26-1920		48 YRS.						5-28-69 19 10: 30am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Riverdale		Leland Memorial Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Prince George's		Banner		4533 Banner Street					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Unknown								Lucille ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
						LUCILLE BARBOUR-MOTHER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 4121 DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive arteriosclerotic heart</u> disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 5-28-69	
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		6/2/1969		HARMONY		LANDOVER		MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. ERNEST JARVIS JR.		1432 U.S. STREET		JUN 6 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07301

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07298

1. DECEASED-NAME (Type or print) Agatha First E. Middle Carpenter Last			2a. DATE OF DEATH Month May Day 8 Year 1969			2b. HOUR 2:00 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 11/21/01		6. AGE (In years lost birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.	
10. CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown - Retired		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1909 Rosedale Street, N.E.		14. FATHER'S NAME First Robert Middle Jackson Last Chapman		15. MOTHER'S MAIDEN NAME First Rose Middle Chapman Last Chapman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4369 IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent cerebrovascular accidents DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic glomerulonephritis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/21 , 19 68 , to 5/8 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/8 , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE Moe Weiss				22c. DATE SIGNED 5/8/69			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE Burial 5-12-1969		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR W. E. Varun Co.		ADDRESS 1432 1st St. N.W.		25a. REC'D BY REGISTRAR MAY 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07302									
07299									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Lula			B. Carter			5 / 19 / 69		5:30P M	
3. SEX			4. RACE			5. DATE OF BIRTH		6. AGE (In years last birthday)	
F			N			6/15/96		72 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Va.			USA					Prince Georges, Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glenn Dale			Glenn Dale Hospital			retired		unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						Washington, D.C.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
Charles			Mamie			1165 3rd St., N. E.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no			579-44-7875			decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute myocardial infarction 3 days									
4109 DUE TO, OR AS A CONSEQUENCE OF									
(b) Coronary arteriosclerosis years									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Generalized arteriosclerosis years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 10/20/19 67, to 5/19/19 69, that (X) (we) last saw the deceased alive on 5/19/69 19, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
Moe Weiss			5/19/69			Glenn Dale Hospital, Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
X			5-23-69			Arlington National Cemetery Ft. Myer, Arlington, Va.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Hall Bros. - n.w. Wash D.C.			621-7100			MAY 22 1969 Charles Judge			

SPCVA

2015

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BOOK REVIEW

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ABSTRACT

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Glenn County Hospital, Glenn, Calif.

Spade 10000

7-2-2-3 22 22 22

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23 Film 413
6/9/69 kk

07303

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07300

| | | | | | | | | | | | | | |
|--|---------|------------------------------|--|--|-----------------|------------------------------------|------------------|---|----------------------------------|--|--|--|----------|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 5-20-69 1910:00am | | | | 2b. HOUR | |
| William | | L | | Cashion | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR |
| Male | White | 9-2-1924 | | 44 1/2 YRS. | MONTHS | | DAYS | | Month 5 Day 24 Year 69 19 6:02pm | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Virginia | | USA | | | | Prince George's Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | | Prince George Hospital | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Virginia | | | | Chesterfield | | Richmond | | | | 9620 Jefferson Davis Hgway. | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | |
| Herbert R. Cashion | | | | | | | | | | Vada Holmes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Drowning</u>
9109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
10:00am 5-20-69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
undetermined | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Anacostia river, Bladensburg, Prince George County, Maryland | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | | | 22b. DATE SIGNED
5-26-69 | | | |
| John Kehoe MD | | | | Riverdale, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 5/28/1969 | | Mt. Calvary Cemetery | | | | Richmond, Virginia | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | |
| Falls Church Funeral Home, | | | | Falls Church, Va. | | | | JUN 2 1969 | | | | Charles Judge | |

07303

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Chesapeake Bay

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 113
5/29/69 kk
Items #2a, Film 113 6

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07301

| | | | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type and print)
07304 Moses | | First | | Middle | | Last
Cattman | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> May 15 1969 | | 2b. HOUR
9:00 M | |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
5-8-21 | | 6. AGE (In years
last birthday)
49 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 5-15- Year 1969 | |
| 7a. BIRTHPLACE (State or foreign country)
U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Bladensburg | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Dick's Prince Geo Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Prince Geo. | | 13c. CITY OR TOWN
Brentwood | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
4519 41st Street | | | |
| 14. FATHER'S NAME
First unk Middle unk Last unk | | | | 15. MOTHER'S MAIDEN NAME
First unk Middle unk Last unk | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
145-28-8350 | | 17. INFORMANT
none | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Advanced nutritional cirrhosis of liver
DUE TO, OR AS A CONSEQUENCE OF
(c) Edema and congestion of lungs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Victor A. Fazekas, M.D. | | 22b. DATE SIGNED
5-17-69 | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5-21-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem. | | 23d. LOCATION (City or Town) (County) (State)
Spitland Rd Md | | 24. FUNERAL DIRECTOR
H. S. Washington Sons | | | |
| 25a. REC'D BY REGISTRAR
MAY 23 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |

07304

010

Minneapolis

Special Agents

Advanced Technical Division of FBI

Lead and Identification of Lead

Lead

Lead

Victor E. Palmer, I.D.

May 2 1938

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|---|---|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Irene | | | First Middle Lost | | | 2a. DATE OF DEATH
May Month 4 Day Year 69 | | | 2b. HOUR
10:55 | |
| 3. SEX
Female | | 4. RACE
Colored | | 5. DATE OF BIRTH
09-08-17 | | | 6. AGE (In years lost birthday)
51 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Prince George Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George General | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Prince Geo. | | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Box 405 Grant Ave. |
| 14. FATHER'S NAME First Middle Lost
George Brooks | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
Priscilla Caren | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS
1519 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of the stomach (c) (Linitis Plastica)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH abt 6 months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION
5/3/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Felix Flores | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/4/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
FELIX FLORES | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/9/69 | | 23c. NAME OF CEMETERY OR CREMATORY
CARVER MEMORIAL PARK | | | 23d. LOCATION (City or Town) (County) (State)
LAUREL Md. | | | |
| 24. FUNERAL DIRECTOR
Robert L. Snowden | | | | | ADDRESS
Rockville, Md. | | 25a. REC'D BY REGISTRAR
MAAY 8 1969 | | 25b. REGISTRAR'S SIGNATURE
G. L. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--------|---|--------------------------|---|--------------------------------|
| 07306 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07303 | |
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR |
| Paul | | | | Cocchiaro | May Day 14, 1969 | | 2:20 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS |
| Male | | White | | 10-21-78 | | 90 YRS. | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Italy | | USA | | | | Prince Georges Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Riverdale | | Eugene Leland Memorial Hospital | | P. COAL-MINER | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | Prince Georges | | Bladensburg | | 5405 Tilden Road | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First Middle Last |
| Ignatius | | | | Cocchiaro | Giovanni | | Belliziere |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | | | 577124026A | | daughter/Medical Record CORNIE PANELLA. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4109 | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-7, 1969, to 5-14, 1969, that (I) (we) lost saw the deceased alive on 5-14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | D. R. Purdie, M.D. | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) | | D. R. PURDIE, M.D. | | 22e. ADDRESS | | RIVERDALE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| BURIAL | | 5-17-1969 | | FORT LINCOLN CEM. | | COLMAR MANOR, MD | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| W. W. CHAMBERS CO. | | RIVERDALE, MD | | MAY 19 1969 | | Charles Judge | |

07306

CERTIFICATE OF DEATH

STATE OF NEW YORK

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07307

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07304

| | | | | | | | | | | | | | | | | | | | |
|---|---------|------------------------------|--|--|--|-----------------|--|--|--|--------------------------|--|---|--|------|--|------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | | Day | | Year | | 2b. HOUR | | | |
| Lleullyn | | | | | | Cofield | | 5 | | 9 | | 19 | | 69 | | 8:45 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | Month | | Day | | Year | | | |
| M | Negro | 3 Nov 1968 | | 5 YRS. | | 5 MONTHS | | 6 DAYS | | 5 | | 9 | | 19 | | 69 | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | | | | | | | |
| Pa. | | USA | | WIDOWED | | DIVORCED | | Prince George | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| Cheverly | | | | Prince George Hosp | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET AND NUMBER | | | |
| Md. | | | | Prince George | | | | Hyattsville | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 7290-B 79th Ave. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Henry Cofield | | | | Diane Franklin | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | |
| | | | | | | | | Henry Cofield, Hyattsville, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
884X
DUE TO, OR AS A CONSEQUENCE OF
Cerebral concussion
Skull fracture 11cm.
Trauma
5 hrs. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY? | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
3:04 P.M. 5 9 19 69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fell off bed | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
Bedroom | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
7290-B 79th Ave., Hyattsville P.G. Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
5-10-69 | | | | | | | |
| 23a. BURIAL CREMATION
REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | 5/12/69 | | | | Douglas Cemetery | | | | Alexandria, Va. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | Greene Funeral Home, Alexandria, Va. | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| | | | | | | | | MAY 13 1969 | | | | Charles Judge | | | | | | | |

01307

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) FRANK | | | | | | 2a. DATE OF DEATH MAY 11 1969 | | 2b. HOUR 2:15 PM | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH 1-2-1885 | | 6. AGE (In years last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGES Md. | | | | | |
| 10. CITY OR TOWN OF DEATH FORESTVILLE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) wire hatter foreman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY PRINCE GEORGES | | 13c. CITY OR TOWN Forest Hts | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 341 Huron Dr | |
| 14. FATHER'S NAME First Middle Last Unknown | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no | | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT Marie Connolly, Wife Address 341 Huron Drive, S.E., Forest Heights, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac arrest. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF myocardial infarction | | | | | | | | | | | |
| (b) atherosclerotic heart disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF myocardial infarction | | | | | | | | | | | |
| (c) myocardial infarction | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Stroke, Pneumonia - urinary tract infection | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 5-11-69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased, from 5-11-69 , to 5-11-69 , that (I) (we) last saw the deceased alive on 5-11-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Oliver B. Bond | | | | | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5-12-69 | |
| 22d. PHYSICIAN'S NAME (Type) OLIVER B. BOND MD | | | | | | 22e. ADDRESS 7420 MARLBORO PIKE FORESTVILLE MARYLAND 20028 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 5/16/69 | | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) Grasmere, Staten Island, NY | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm | | | | | | ADDRESS 4308 Suitland Rd., S.E., Suitland, Md., 20023 | | 25a. REC'D BY REGISTRAR MAY 15 1969 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

7635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1 | | 07309 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 08778 | |
| Item 23 | | Film 413 | | 6/18/69 | | kk | |
| 1. DECEASED-NAME
(Type or print) | | First
BELINDA | | Middle
ALSTON | | Last
CORDELL | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
26 May 1969 | | 2a. DATE OF DEATH
Month MAY Day 26 Year 69 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2b. HOUR P
1023 M | |
| 10. CITY OR TOWN OF DEATH
Camp Springs | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Malcolm Grow USAF Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Suitland | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First
MC GRADY | | Middle
CORDELL | | Last
ISABEL | | 15. MOTHER'S MAIDEN NAME
First
ISABEL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No (or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
McGrady Cordell, 3807 Swann Rd Suitland, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
7639
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Sepsis
(c) Maternal Amnionitis | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 Hrs
5 Hrs
1 Day | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Prematurity | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) the hospital attended the deceased from 26 May , 19 69 , to 26 May , 19 69 , that (I) was lost saw the deceased alive on 26 May , 19 69 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (does) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Richard W. Dodds</i> MD | | 22c. DATE SIGNED
26 May 69 | | 22d. PHYSICIAN'S NAME (Type)
RICHARD W. DODDS, | | 22e. ADDRESS
Malcolm Grow USAF Hospital Andrews AFB MD | |
| 23a. BURIAL (CREMATION) REMOVAL (Specify) | | 23b. DATE
6/13/69 | | 23c. NAME OF CEMETERY OR CREMATORY
PUBLIC CREMATION | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | |
| 24. FUNERAL DIRECTOR
<i>Carl F. Oufertt</i> | | 25a. REC'D BY REGISTRAR
DATE JUN 12 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 07310 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07306 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Hardie Council | | | 2a. DATE OF DEATH
Month Day Year
May 15 1969 | | | 2b. HOUR
1:35 A.M. | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
5/24/1906 | | 6. AGE (In years last birthday)
62 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | |
| 10. CITY OR TOWN OF DEATH
Glenn Dale | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Glenn Dale Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Unknown | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1412 Massachusetts Ave. S.E. | |
| 14. FATHER'S NAME First Middle Last
Min Council | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ann E. Jenkins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
578-16-9183 | | 17. INFORMANT
Decedent Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism, multiple
4123 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
(c) years | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular accident; generalized arteriosclerosis; probable pulmonary tuberculosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/25/1969 , to 5/15/1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/15/1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Moe Weiss | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/15/69 | |
| 22d. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | | | 22e. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/20/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Maryland | |
| 24. FUNERAL DIRECTOR
Stewart | | | | 25a. REC'D BY REGISTRAR
MAY 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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Q. H. 62161, 90?

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07311

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07307

| | | | | | | | | | | | |
|---|---------|------------------|---|---|--|---|--|---|---|--|------------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 20. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5-4-69 | | | 2b. HOUR
197:25am M | | |
| LeRoy | | | Craig | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR |
| Male | White | 2-6-1902 | 67 YRS. | | | | | 5 4 69 | | | 197:32am M |
| 70. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Ohio | | | U. S. A. | | | | | | Prince George's Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Cheverly | | | Prince George Hospital | | | Ret. Inspector | | | Carbide Co. | | |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Prince George's | | | Lanham | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Robert | | | Craig | | | Unknown | | | Margaret Craig | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | | 17. INFORMANT | | | ADDRESS | | |
| Unknown | | | | | | Margaret Craig | | | Glen Freeis, W. Va. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
4123
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease
Conditions, if any, which gave
rise to immediate cause (a).
stating the underlying cause
last. (b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes
over 3 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S
NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 5-5-69 | | | |
| John Kehoe MD | | | | Rivendale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 230. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATOR | | | |
| Burial | | | | 5/7/69 | | | | Montgomery Mem. Park London Kanawha W. Va. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 250. REC'D BY REGISTRAR | | | |
| Francis Gasch's Sons Hyattsville, Maryland | | | | | | | | DATE MAY 7 1969 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | Francis Gasch | | | |

11650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|---|--|--|--|---|---|---|---|---|
| 07312 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07308 | | |
| CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR |
| Wesley | | | Warren | Cromwell, Sr. | May | 22 | 1969 | 9 P M |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12-22-89
Nov. 2, 1897 | | 6. AGE (In years
last birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gen. Hosp | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Cattle Ranch Farm | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Ranch |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution:
admission) STATE
Montana | | 13b. COUNTY
Daniels | | 13c. CITY OR TOWN
Scobey | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Box 351 Gen. Delivery |
| 14. FATHER'S NAME
First Middle Last
Charles Fremont Cromwell | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Lennie -- Ward | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No -- | | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Mrs. Myrtle Cromwell- Scobey, Montana. | | | Address Gen. Delivery, |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C. V. A
4369 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) Generalized Arteriosclerotic disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) this hospital attended the deceased from May 17, 1969, to May 22, 1969, that (X) (we) last saw the deceased alive on May 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Rene Gomez | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
5/23/69 | | |
| 22d. PHYSICIAN'S
NAME (Type)
RENE GOMEZ | | | | 22e. ADDRESS
Prince Georges Gen. Hospital,
Cheverly, Maryland. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5/27/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Scobey Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Scobey- Daniels-Mont. | | |
| 24. FUNERAL DIRECTOR
Ritchie Bros. Fun'l Home- Upper Marlboro Maryland 20870 | | | | 25a. REC'D BY REGISTRAR
DATE MAY 29 1969 | | 25b. REGISTRAR'S SIGNATURE | | |

41272

Chen et al.

1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 26

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44 2 9 63020011

Charles Fremont Crowell.

— signed

Mr. Myrtle Cromwell - 30000

01000 00000

Accoy Company

1000-2000-2000

[Faint, illegible text at the bottom of the page]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|--|------|---|-----|---|---|
| 07313 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | 07309 | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Ethel K Curtis | | | | | | Month Day Year | | | 8:30 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| F | W | 9 Sept 1914 | 54 YRS | MONTHS | DAYS | HOURS | MIN | Month Day Year | 2d. HOUR |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 2d. HOUR | |
| Ohio | | U.S.A. | | | | Prince George | | 9:06 PM | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Clinton, Maryland | | | Clinton Hospital | | | Sears | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? |
| Va. Md. | | | | | | Arlington | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | Rd. |
| Albert Rich | | | Gladys Jarrett | | | 4414 North Carlyn Spring | | | Spring |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS |
| | | | 577-01-6868 | | | Benjamin H. Curtis | | | 4414 Carlyn Springs Rd. Arlington, Virginia |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | Min. |
| 4123 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease | | | | | | | | | unknown |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | HOUR A.M. P.M. | | | 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5-30-69 | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | June 2, 1969 | | Mt. Holly Cemetery | | Remington, Virginia | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Ives Funeral Home | | 2847 Wilson Boulevard Arlington, Virginia | | | | JUN 5 1969 | | James Judge | |

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RECORDS OF THE DEPARTMENT OF AGRICULTURE

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07314

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07310

| | | | | | | | | | | | | | | | |
|---|---------|------------------|--|--------------------------------|--|---|--|---|--|--------|--------|--|----------|------|----------|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | | | Month | Day | Year | 2b. HOUR | | |
| William Maurice Davis | | | | | | 5-20-69 | | | | 19 | 12 | 31am | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | | | Month | Day | Year | 2d. HOUR |
| Male | White | 10-7-1922 | 46 YRS. | | | | | 5-20-69 | | | | 19 | 12 | 50am | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | |
| Oklahoma | | | USA | | | | | | Prince George's Md | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Cheverly | | | Prince George Hospital | | | Asst. Reg. Manager-Boiler Manuf | | | acture | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | | 13c. STREET AND NUMBER | | | 13d. INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| OHIO | | | Steubenville | | | 100 JACKSON DRIVE | | | | | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | | | | |
| William Earl Davis | | | | | | Janette Sanders | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | | | |
| Yes | | | 3/1945-10/1945 | | | Yes. Steubenville, Ohio
Ruth P. Davis, 100 Jackson Drive | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Transection of spinal cord at C-7-T-1</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>and Bilateral hemothorax</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Multiple rib fractures</u>
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | | | | | |
| | | | 12:30am 5-20-1969 | | | Occupant of car involved in collision | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County | | State | | |
| | | | Rt. 495 near Rt. 214, Prince George County, Maryland | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| John Kehoe MD | | | Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | 5-21-69 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | May 24, 1969 | | Hominy City Cemetery Hominy, Osage Co., Oklahoma | | | | | | | | | | |
| Jack Powell Funeral Home, Hominy, Oklahoma | | | Arehart Funeral Home Inc., La Plata, Md. | | | MAY 26 1969 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 07315 CERTIFICATE OF DEATH 07311 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
RENATO SILVINO DEL PINO | | | | | | 2a. DATE OF DEATH
Month 5 Day 4 Year 69 | | 2b. HOUR
1:28 PM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
2-17-22 | | 6. AGE (In years lost birthday)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
CUBA | | 7b. CITIZEN OF WHAT COUNTRY?
CUBA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CIVIL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Lanham | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5417 85th Ave. Apt .1 | |
| 14. FATHER'S NAME First Middle Last
JUAN M. DEL PINO | | | 15. MOTHER'S MAIDEN NAME First Middle Last
CELIA PEREZ | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
(If he gave war or dates of service) | | 17. INFORMANT
Renato | | Address
5417 85th Ave APT #1
LANHAM, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ATHEROSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 HOUR | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 68, to MAY 19 69, that (I) (we) last saw the deceased alive on APRIL 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Fidel J. Quintana | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-4-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
FIDEL J. QUINTANA | | | | | 22e. ADDRESS
8715 FIRST AVE, S. SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MAY 7, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEM. | | 23d. LOCATION (City or Town) (County) (State)
COMAR MANOR, PRINCE GEORGES CO., MD. | | | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS Co. | | | | | ADDRESS
RIVERDALE, MD. | | 25a. REC'D BY REGISTRAR
MAY 8 1969 | | 25b. REGISTRAR'S SIGNATURE | |

03315

1870

DEATH

Place

CUBA

Country

Washington, D.C.

M. J. J. J.

No.

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

10-20-10

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07312

| | | | | | | | | | | | | | | | | | |
|---|--|--------------|------------------|--|--|--|--|---|----------------|---|--|--|--|---|---------------------|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
Richard | | | Middle
Elzzie | | | Last
Dement | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input type="checkbox"/> 5 29 19 69 | | | 2b. HOUR
5:10 PM | | |
| 3. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
May 19, 1892 | | 6. AGE (In years
last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 5 Day 29 Year 19 69 | | | 2d. HOUR
5:25 PM | | |
| 7a. BIRTHPLACE (State or foreign
country) Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Prince George Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George Hosp. | | | | 12a. USUAL OCCUPATION (Kind at work done
during most of working life, even if retired.)
Farming | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Tobacco | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | | 13b. CITY OR TOWN
Prince George | | | | 13c. CITY OR TOWN
Clinton | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7838 Den Lee Drive. | | | |
| 14. FATHER'S NAME
First Middle Last
James E. Dement | | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Sara V. Jenkins | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
WW1 | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
217-36-6922 | | | | 17. INFORMANT
9411 Jackson Ave.
Richard Dement Ft. Wash., Forrest, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Arteriosclerotic heart disease unknown
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Min. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | | | John Kehoe, M.D., Riverdale | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE
6-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Resurrection | | | | 23d. LOCATION (City or Town) (County) (State)
Clinton Pr. Geo. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR
Huntt Funeral Home Waldorf, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JUN 9 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | | | | | | | |

07316

James

James

X

James B. Howard

177-1-1002

177-1-1002

177-1-1002

FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 6&24 Film G13
6/9/69 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23b, Film G13 6/11/69

07313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--------------|--|--|---|---|---|---|
| 1. DECEASED NAME (Type or print)
07317 Helen Lydia DiFrancesco | | First Middle Last | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 5 31 1969 | | 2b. HOUR
6:00 AM | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
14 Dec., 1912 | | 6. AGE (In years last birthday)
52 5/8 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month 5 Day 31 Year 19 69 |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George Md. | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Hillside | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
GEORGE T. DUDLEY | | 15. MOTHER'S MAIDEN NAME First Middle Last
CHARLES LAVENIA WOODBRIDGE | | 13e. STREET AND NUMBER
5290 Marlboro Pike | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
237-22-4048 | | 17. INFORMANT ADDRESS
Frank J. DiFrancesco 5290 Marlboro Pike Hillside, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Coronary artery occlusion days
(c) Arteriosclerotic heart disease yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | John Kehoe, M.D., Riverdale | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
6-1-69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
June 3, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
MAURY CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
Richmond, VA. | |
| 24. FUNERAL DIRECTOR
Joseph W. Bliley Funeral Home, Richmond, Va. | | 25a. REG'D BY REGISTRAR
DATE JUN 5 1969 | | 25b. REGISTRAR'S SIGNATURE
Richard J. Judge | | | |

04317



17461
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 07318 | | | | | | | | | |
| 07314 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Velma F. Dillman | | | | | 2a. DATE OF DEATH
Month Day Year
May 16 1969 | | | 2b. HOUR
11:40PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
2/24/17 | | 6. AGE (In years
last birthday)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
N. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
College Park | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4805 Delaware St. | |
| 14. FATHER'S NAME
First Middle Last
James Henry Dillman | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Florence High | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
no | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address
Mr. Jesse E. Dillman Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Ca to lungs & vertebrae C-7-T12</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Adenocarcinoma of Rt breast 5 years</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>174X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 19 1969</u> , to <u>May 16 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 16 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>W. C. Weintraub</u> | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/17/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
William C. Weintraub, M.D. | | | | | 22e. ADDRESS
Professional Bldg., Greenbelt, Md. 20770 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/20/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor P.G. Md. | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR
MAY 20 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

1709

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|-----------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 07319 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 07315 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
DAWN M DINGELDEIN | | | | | | 2a. DATE OF DEATH
Month 27 Day 69 Year
MAY | | | 2b. HOUR a
5:50 M | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN White | | 5. DATE OF BIRTH
14 Oct 53 | | 6. AGE (In years last birthday)
15 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MICH | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
ANDREWS AFB | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MALCOLM GROW USAFHOSP | | | | 12a. USUAL OCCUPATION (Kind of work done during months of working life, even if retired.)
STUDENT | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Schools | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. CITY OR TOWN
PRINCE GEORGE ANDREWS | | 13c. CITY OR TOWN
AFB | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3845 MICHIGAN AVE | | | |
| 14. FATHER'S NAME First Middle Last
CURTIS FRED DINGELDEIN | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
JOYCE MARY MICHAUD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT Address
FATHER SAME AS ITEM #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1709 METASTASIS TO LUNG
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) OSTEOGENIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 Months
14 Months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 21 May , 19 69 , to 27 May , 19 69 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on 27 May , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (do) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jeffrey A. Graham DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
27 May 69 | | | | | |
| 22d. PHYSICIAN'S NAME
JEFFREY A GRAHAM CAPT USAF MC | | | | | | 22e. ADDRESS
MALCOLM GROW USAFHOSP ANDREWS AFB | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/30/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Mikado Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Mikado | | Michiga | |
| 24. FUNERAL DIRECTOR ADDRESS
Ritchie Bros. Upper Marlboro, Md. | | | | | | 25a. REC'D BY REGISTRAR
MAY 29 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

07313

DAWN

DINGELDEIN

MAY

27 68

FEVALE

11-000 50

12

PRINCE GEORGE

U.S.A.

HIGH

ANDREWS AFB

MAJOLIN GROW USATHOS? STUDENT

MARYLAND

PRINCE GEORGE ANDREWS

X

1800 S MICHIGAN AVE

CURTIS ERNE DINGELDEIN

JOHN

MARY

MICHIGAN

NO

FATHER'S NAME AS ITEN 415

RETASTASIS TO LUNG

OSTEOGENIC CARCINOMA

5 Months

18 Months

NO

X

X

27 May

27 May

27 May

27 May

27 May

27 May

X

GEORGE A GRAHAM CAPT USAF MC

MAJOLIN GROW USATHOS ANDREWS AFB

Bureau

2/30/69

Misses Cemetery

Misses

Rivonia Ave., Upper Marlboro, Md.

07320

CERTIFICATE OF DEATH

07316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Prince George</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>MARYLAND</i> b. COUNTY <i>Pt. Geo</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>FOREST HEIGHTS</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>FOREST HEIGHTS</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>103- Seneca Dr SE</i> | | d. STREET ADDRESS
<i>103- Seneca Dr SE</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>Archiebald Vincent Dixon</i> | | 4. DATE OF DEATH
Month <i>MAY</i> Day <i>6th</i> Year <i>1969</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>MAR. 21-1899</i> |
| 9. AGE (In years lost birthday) <i>70</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Reta DC. Police - Dept.</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>Samuel Dixon</i> | | 14. MOTHER'S MAIDEN NAME
<i>Mamie White</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>217-36-6344</i> | |
| 17. INFORMANT
<i>Virgie M. Dixon - Wife - SAME AS Item #</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4109</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)
<i>Coronary Thrombosis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <i>19</i> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>May 6</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 15</i> , 19 <i>68</i> , and that death occurred at <i>5 A</i> M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Frank J. Talbot MD</i> | | 22b. DATE SIGNED
<i>5/6/69</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Frank J. Talbot MD</i> | | 22d. ADDRESS
<i>4273 Branch Ave SE
Marlow Heights Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>5-9-1969</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Suitland, Maryland</i> |
| 24. FUNERAL DIRECTOR
<i>Simmons Bros.</i> | | 25a. REC'D BY REGISTRAR
<i>MAY 8 1969</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

05851

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07321

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07317

| | | | | | | | | | | | | | |
|--|---------|------------------------------|--|---|-----------------|---|------------------|---|--|---|--|--|----------|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 20. DATE KNOWN OF DEATH | | | | 2b. HOUR | |
| William | | O | | Dobbins | | <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year
<input type="checkbox"/> 5-17-69 <input type="checkbox"/> 12:05am | | | | 12:05am | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR |
| Male | White | 7-9-1908 | | 60 YRS. | MONTHS | | DAYS | | Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>
5-17-69 Day Year 19 11:11am | | | | 11:11am |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | Md. |
| Selma, Ala. | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Prince George's | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | | Prince George Hospital | | | | Engineer | | | | Planning | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | P.G.Co. | | Silver Spring | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 9203 New Hampshire Ave. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| William O. Dobbins | | | | Mary Cothran | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| no | | | | 420 34 0527 | | Cherry Chase, MD
William O. Dobbins III 3553 Hamlet Pl. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Total injuries | | | | | | | | | | | | | |
| 805X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | 10:05am 5-17- 19 69 | | | | Struck by train | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | Glen Dale Crossing near | | | | Duvall Rd., Glen Dale, Md. P.G. Co. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 5-18-69 | |
| John Kehoe MD | | | | Riverdale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | | | 5/20/69 | | Cedar Hill Crematory | | | | Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | Wash. D.C. | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Joseph Gawler's Sons, 5130 Wisconsin Av., NW | | | | | | | | MAY 23 1969 | | Charles Judge | | | |

07881

USA

William O. Robbins

450 N. 0577 William O. Robbins III 2555 Harlow St.
Greenville, NC

Harry Robbins

7/20/09

Order Will Cemetery

Chillicothe, Maryland

Joseph Gaylor's Sons, 2130 Wisconsin Ave., N.W.
Washington, D.C.

2555 Harlow St.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1012-M. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07322

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07318

| | | | | | | | | | | | | | | | | | |
|---|--|--------------|------------------|--|--|---|--|---|----------------|-------------------------------|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
William | | | Middle
John | | | Last
Dunlap | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5 Month 10 Day 1969 | | | 2b. DATE PRONOUNCED DEAD
Month 5 Day 10 Year 1969 | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
22 June 1924 | | 6. AGE (In years
last birthday)
44 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 7c. COUNTY OF DEATH
Prince George | | | Md. | | |
| 7a. BIRTHPLACE (State or foreign
country) Pitts, Pa. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Camp Springs | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Andrews Air Force Hosp | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) Sales Mgr. | | | | 12b. KIND OF BUSINESS OR
INDUSTRY Auto | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE Md | | | | 13b. COUNTY Prince George | | | | 13c. CITY OR TOWN Hillcrest | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 3200 Curtis Drive | | | |
| 14. FATHER'S NAME First Middle Last
Frank M. Dunlap | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lucille Ratajeski | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | | | | | 16b. SOCIAL SECURITY NO.
WW. 11 | | | | | | 17. INFORMANT ADDRESS
Lorraine B. Dunlap 2205-Afton St. SE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4123 Heart failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) Unknown | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Min | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
5-10-69 | | | | | | | | | |
| 23a. BURIAL CREMATION <input checked="" type="checkbox"/> | | | | 23b. DATE
May 13-69 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem. Arlington, Virginia | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| 24. FUNERAL DIRECTOR
Simmons Bros. | | | | ADDRESS Wash., DC | | | | 25a. REC'D BY REGISTRAR
DATE MAY 13 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Paul | | | E. Egenreider | | | May 5 1969 | | 11 30 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Male | | White | | Oct. 9, 1908 | | 60 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Pennsylvania | | U. S. A. | | | | Prince George | | Paint Factory | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Greenbelt | | | 73 G. Ridge Road | | | Factory Worker | | Factory | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | P. G. | | Greenbelt | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 73 G. Ridge Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| John Egenreider | | | Catherine Bickner | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| | | | 195 07 1830 | | Shirley Ann Egenreider Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1968, to 3 MAY 1969, that (we) last saw the deceased alive on APRIL 19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | |
| Arthur Kaufman | | 4 May 69 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| Arthur Kaufman, M. D. | | Greenbelt, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5/7/69 | | East Harrisburg Cemetery | | Harrisburg Dauphin Pa | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Francis Gasch's Sons Hyattsville, Maryland | | | | MAY 7 1969 | | Charles Judge | | | | |

TESTIMONY OF JOHN

JOHN H. HARRIS, JR. (PHOTOGRAPH BY J. H. HARRIS, JR.)

JOHN H. HARRIS, JR.

JOHN H. HARRIS, JR.

JOHN H. HARRIS, JR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07320

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
ELROD MARY ELMA ELROD | | | 2a. DATE OF DEATH
Month MAY Day 16 Year 1969 | | | 2b. HOUR
0130 M | |
| 3. SEX
FEMALE | | 4. RACE
CAU | | 5. DATE OF BIRTH
16 NOV 1911 | | 6. AGE (In years last birthday)
57 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
GEORGIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGE'S Md. | |
| 10. CITY OR TOWN OF DEATH
ANDREWS A.F. BASE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MALCOLM GROW USAF HOSP | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
OFFICE | | 12b. KIND OF BUSINESS OR INDUSTRY
MILITARY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE VA. | | 13b. COUNTY
ARLINGTON | | 13c. CITY OR TOWN
ARLINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1310 N. OAK ST. | | 14. FATHER'S NAME First DATON Middle - Last ELROD | | 15. MOTHER'S MAIDEN NAME First BLANCHE Middle - Last IRVIN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give war or dates of service) W.W. II | | 16b. SOCIAL SECURITY NO.
252-03-4678 | | 17. INFORMANT
MARGERY K. GUMBEL | | Address 4530 KLINKLE ST. N.W. WASHINGTON, D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
1621
DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL METASTASES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Aspiration of Food
DUE TO, OR AS A CONSEQUENCE OF
(c) Adenocarcinoma of Lung | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7 May , 19 69 , to 10 May , 19 69 , that (I) (we) last saw the deceased alive on 10 May , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Jeffrey S. Steer MD | | DEGREE MD | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
10 May 69 | |
| 22d. PHYSICIAN'S NAME (Type)
JEFFREY STEER | | 22e. ADDRESS
MALCOLM GROW HOSPITAL ANDREWS AIR FORCE BASE, DC. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-14-69 | | 23c. NAME OF CEMETERY OR CREMATORY
West View Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Atlanta Georgia | |
| 24. FUNERAL DIRECTOR
W.W. Chambers Co. | | ADDRESS
1400 Capital | | 25a. REC'D BY REGISTRAR
MAY 14 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|--|---|---|---|---|---|---|-----------------|--|
| 07325 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07321 | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Ely B. Ely | | | 2a. DATE OF DEATH
Month Day Year
May 1 1969 | | | 2b. HOUR
150 P. M. | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10-29-82 | | 6. AGE (In years
last birthday)
86 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverley | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Mt. Rainier | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
First Middle Last
William Billingsley | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Eleanor Grambrill | | | 13e. STREET AND NUMBER
3109 Bunker Hill Rd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Husband
Harry K Ely | | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
4409 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio-Sclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/25, 1969, to 5/1, 1969, that (I) (we) last saw the deceased alive on 5/1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles C. Hageage M.D. | | | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 1, 1969 | | |
| 22d. PHYSICIAN'S
NAME (Type)
Charles Hageage, M.D. | | | | | 22e. ADDRESS
3308 Perry St. Mt. Rainier, Md. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
5/3/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln cem. | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor, Md. | | | |
| 24. FUNERAL DIRECTOR
Nalley's Funeral Home Inc. | | | | | ADDRESS
Mt. Rainier,
Maryland | | 25a. REC'D BY REGISTRAR
MAY 6 1969 | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

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CORPORATE OF DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| | | | | | | | | | | | | | | | | | |
|---|--|---|---|--|------------------------------------|---|------|--|---|---|--------------------------------|---|-------------------------------|--------|--|------|--|
| 07326 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07322 | | | | | | | | | | | |
| Martha | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| Martha | | | MARIE | | ETCHISON | | | | Month Day Year
5 24 69 | | M | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | | |
| F | | | Caucasian | | | 12-18-88 | | | 80 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | |
| WASHINGTON, D.C. | | | U.S. | | | | | | Prince Georges Co., Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | |
| Cheverly | | | PUGH E.E.F. | | | HOUSEWIFE | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | |
| Md. | | | PRINCE GEORGES | | | New Carrollton | | | | | 7701 Archant Drive | | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First | | Middle | | Last | |
| NOBEL | | | S. | | COOK, | | | | IDA | | | WEEDON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | |
| NO | | | 220-540244 | | | MRS. IDA V. STEWART | | | 12706 CALDWELL ST
ROCKVILLE, MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac & Respiratory Arrest.
180X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) Metastatic Carcinoma of Perit.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
Anemia | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | Thipavan Thanudape M.D. | | | | | 22c. DATE SIGNED | | 6-24-69. | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | THIPAVAN THANUDAPE | | | | | 22e. ADDRESS | | PRINCE GEORGE'S GENERAL HOSPITAL, MD | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | |
| BURIAL | | | 5-27-1969 | | FORT LINCOLN CEM | | | COLMAR MANOR, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| W.W. CHAMBERS Co. | | | RIVERDALE, MD | | | | | MAY 27 1969 | | Charles Judge | | | | | | | |

03883

STATE OF TEXAS

County of _____

Know all men by these presents, _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ of the County of _____ State of Texas, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____

Witness my hand and seal this _____ day of _____ 19____.

Notary Public in and for the State of Texas

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07327

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08796

| | | | | | | | | | | | | | | | |
|--|--|---------|-------------------|--|--|------------------------------------|--|--|----------------|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | |
| John W Ewell | | | | | | 5-16-69 | | | 19 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | | |
| Male | | White | | 12-16-1916 | | 52 YRS. | | | | | | Month Day Year 6 6 69 19 1:00pm M | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | | | U.S. | | | | | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Mt. Rainier | | | | 3121 Queens Chapel Rd. 301 | | | | ATTORNEY AT LAW | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. CITY OR TOWN | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Prince George's Mt. Rainier | | | | | | | | 3121 Queens Chapel Rd. 301 | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | |
| JOHN E. EWELL | | | | WILKINA DANTZ | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| YES | | | | KOREAN | | | | 216-16-5824 | | | | MR. DOUGLAS W. EWELL 2704 KIRKWOOD PL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Liver failure | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Cirrhosis of liver | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 6-7-69 | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | | JUNE 10, 1969 | | BALTIMORE NATIONAL | | | | BALTIMORE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.W. Chambers Eco Riverdale, Md. | | | | | | | | JUN 12 1969 | | | | Charles Judge | | | |

07337

07330

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 04-11-2000 BY SP-6 JLM/STW

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18-22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07323

| | | | | | | | | | | | | | | | |
|---|---------|--|--|--|-----------------|--|------------------|--|-----------------------------------|---|--|---|----------|-------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 5-13-69 19:00am | | | | 2b. HOUR | | | |
| Raymond | | H | | Ferguson | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | |
| Male | White | 12-6-1891 | | 77 YRS. | MONTHS | | DAYS | | Month 5 Day 13 Year 69 19 11:05am | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | Md. | |
| WASH.D.C. | | USA | | | | Prince George's | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | | | Prince George Hospital | | | | FARMING | | | | TRUCK FARMER | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Prince George's | | | | Oxon Hill | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1514 Ferguson Lane | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| ANDREW | | FERGUSON | | | | | | ANNIE | | A. | | MOORE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | |
| NO | | 213-38-2627 | | MRS.MARY MAYOR - SCOTLAND,MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute carbon monoxide intoxication</u>
9520
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
8:00 AM 5-13 19 69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Connected rubber hose from exhaust pipe to interior of car. | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Garage of home | | | | 21f. LOCATION Street or R.F.D. No.
Oxon Hill | | | | City or Town
P.G. | | County
Md. | | State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe MD | | | | Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
5-13-69 | | | |
| EXAMINER'S NAME (Type) | | John Kehoe MD | | | | Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | | | | | ADDRESS(Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
5/16/69 | | 23c. NAME OF CEMETERY OR CREMATORY
ST.MICHAELS CEM. | | | | 23d. LOCATION (City or Town) (County) (State)
RIDGE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
John M. Welch | | | | ADDRESS
JOHN M. WELCH - LEONARDTOWN, MD. | | | | 25a. REC'D BY REGISTRAR
MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

03070

7-20-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

183X

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07329

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07324

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) William C. Fones | | | 2a. DATE OF DEATH
Month 5 Day 13 Year 69 | | | 2b. HOUR
12:30 M | |
| 3. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
6/3/1886 | | 6. AGE (In years last birthday)
82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | |
| 10. CITY OR TOWN OF DEATH
Forestville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Regent Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Govt. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia | | 13b. COUNTY
Arlington | | 13c. CITY OR TOWN
Arlington | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
702 South 22nd Street | | 14. FATHER'S NAME
First Henry Middle Fones | | 15. MOTHER'S MAIDEN NAME
First Julia Middle Hall | | 16. SOCIAL SECURITY NO. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | 17. INFORMANT
Henry A. Monroe, Friend | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of prostate
DUE TO, OR AS A CONSEQUENCE OF (c) unfrozen
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
5/17/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Prostatectomy | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/11/1966 to May 13, 1969 , that (I) (we) last saw the deceased alive on May 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Henry J. Hatley | | | | DEGREE
HENRY J. HATLEY | | 22c. DATE SIGNED
May 14 69 | |
| 22d. PHYSICIAN'S NAME (Type)
HENRY J. HATLEY | | | | 22e. ADDRESS
4601 Melrose Ave No | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/16/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Providence Meth. Church Cem. | | 23d. LOCATION (City or Town) (County) (State)
Montross, Virginia | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home | | | | 25a. REC'D BY REGISTRAR
MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| 4308 Suitland Rd., S.E., Suitland, Md., 20023 | | | | | | | |

07582

STATE OF OHIO

IN SENATE

1881

January 1st

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1881

07330

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7 & 13 Film G413 6/5/69 kk

CERTIFICATE OF DEATH

07325

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) <u>Anna</u> | | First <u>S.</u> Middle <u>FORSBACKA.</u> Last | | 2a. DATE OF DEATH
<u>May</u> Month <u>29</u> Day <u>69</u> Year | | 2b. HOUR
<u>5:40</u> PM | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
<u>JUNE 6, 1886</u> | | 6. AGE (In years
last birthday) <u>82</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) <u>FINLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>PRINCE GEORGES</u> Md. | |
| 10. CITY OR TOWN OF DEATH
<u>HYATTSVILLE</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,
give street address) <u>HYATTSVILLE NURS
HOME 6500 RIGGS ROAD</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <u>MARYLAND</u> | | 13b. COUNTY
<u>Prince George</u> | | 13c. CITY OR TOWN
<u>Takoma Park</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
<u>MATTHEW</u> | | First <u>HONGELL</u> Middle Last | | 15. MOTHER'S MAIDEN NAME First
<u>W. FORSBACKA.</u> Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>JAENAR W. FORSBACKA.</u> | | Address | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral thrombosis.APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH5 weeks.4124
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardiovascular disease undet.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Uremia

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 15, 1969</u> to <u>May 29, 1969</u> , that (I) (we) last
saw the deceased alive on <u>May 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>William F. Simpson</u> | | DEGREE <u>M.D.</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/29/69</u> | |
| 22d. PHYSICIAN'S
NAME (Type) <u>William F. Simpson M.D.</u> | | 22e. ADDRESS
<u>6216 N.H. Ave NE - DC 20011</u> | | | | | |

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 23a. BURIAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>JUNE 2-1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Georgetown Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville P. Va. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>William F. Simpson</u> | | ADDRESS
<u>254 Cabot St. N.W.
Washington, D.C. 20012</u> | | 25a. RECEIVED BY REGISTRAR
<u>June 2, 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William F. Simpson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4124

07880

07880

CERTIFICATE OF DEATH



[Faint, mostly illegible text from a form, likely containing personal and medical details.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-69

| 07331 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07326 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GEORGE BENJAMIN FOWLER | | | | | | | | | | MAY 3 1969 | | | | | | | | | | 9:15P, M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX MALE | | | | | | | | | | 4. RACE CAUCASIAN | | | | | | | | | | 5. DATE OF BIRTH 7 JULY 1892 | | | | | | | | | | 6. AGE (In years last birthday) 76 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH PRINCE GEORGE'S Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH RIVERDALE | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6501 AUBURN AVE | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) TAXI DRIVER | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | | | | | | | 13b. CITY OR TOWN PRINCE GEORGES RIVERDALE | | | | | | | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 6501 AUBURN AVE. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last SAMUEL FOWLER | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last LAURA BRADY | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NONE (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. 579054562 | | | | | | | | | | 17. INFORMANT TEREHA B. FOWLER Address SAME AS # 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Metastatic carcinoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 8 mo. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung | | | | | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-9-68, 19, to 5-3-69, 19, that (I) (we) lost saw the deceased alive on 5-3-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE John Kehoe | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 5-5-69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) John Kehoe M.D. | | | | | | | | | | 22e. ADDRESS 6300 Riverdale Rd., Riverdale, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | | | | | 23b. DATE 6 MAY 1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATL. CEM | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE, MD | | | | | | | | | | 25a. REC'D BY REGISTRAR MAY 8 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

07331

GEORGE BENJAMIN FOSTER

CAUCASIAN

MALE

MARYLAND

U.S.

1931 AUG 15

RECEIVED

PRINTED ON RECYCLED PAPER

MAY 10

1931 AUG 15

RECEIVED

GRAND

RECEIVED

1931 AUG 15

[Handwritten signature]

RECEIVED MAY 10 1931
MAY 10 1931
RECEIVED MAY 10 1931

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07332

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07327

| | | | | | | | | | | | | | |
|---|---------|--|--|---|--|-----------------------------------|--|---|--|--------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | |
| William | | James | | French | | 5-29-69 19:25am | | | | 12:25am | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | 4-3-1903 | | 66 YRS | | MONTHS DAYS | | HOURS MIN. | | 5 29 69 19:15am | | M | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | |
| Pa. | | U.S.A. | | WIDOWED | | DIVORCED | | Prince George's | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Cheverly | | Prince George Hospital | | Ret. Bar Tender | | Bar | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Pennsylvania | | Allegheny | | Pittsburg | | YES NO | | 606 Cedar Avenue | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | |
| William | | French | | Mary | | ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 3745 Donnett Drive | | | | | | | |
| no | | 210 07 9293 | | Eleanor Sheeler | | Forestville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | | | | minutes | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease | | | | | | | | | | | | over 1 yr. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES NO | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| CAUSE OF DEATH | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| WHILE AT WORK NOT WHILE AT WORK | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER | | | | 5-29-69 | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER | | | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATION | | | | | |
| Burial | | | | 6/3/69 | | | | Northside Catholic | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | | |
| Francis Gasch's Sons | | | | Hyattsville, Md. | | | | JUN 2 1969 | | | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | | | | | Charles Judge | | | | | |

07330



100 2 003

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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

73
16
1

4/23

07333

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07328

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|--|---|--|------------------------|--|------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Madeline B. Frey | | | | | | 5 ^{Month} 13 ^{Day} 69 ^{Year} | | | 120 ^A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | 5/5/ 1915 | | 54 ^{YRS.} | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Virginia | | U.S.A | | | | Prince George Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Riverdale | | | Leland Memorial Hosp. | | | | | | Secretary | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Prince George | | | Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16006 39th. Ave. | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost | | |
| James Boole | | | | | | Della C. Bailey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address Phone | | | | |
| No | | | 056-148912 | | | Hosp. Record | | | Mr. Grady C. Frey (Husband) 779-5095 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | Sudden | | |
| IMMEDIATE CAUSE (a) PULMONARY EDEMA | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CORONARY | | | | | | | | | | | UNKNOWN | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ARTERY DISEASE | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-7, 1969, to 5-13, 1969, that (I) (we) last saw the deceased alive on 5-13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE ATTENDING PHYS. | | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| C.J. Houmann | | | | | | | | | | | | 13 MAY 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | | |
| C.J. HOUMANN | | | | | | RIVERDALE MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 5/16/69 | | Pinecrest Cemetery | | | Sebring, Highlands Fla. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| F. Gasch's Son Funeral Home | | | | | | Hyattsville Maryland | | | Charles Judge | | | | |
| | | | | | | DATE MAY 19 1969 | | | | | | | |

07333

UNITED STATES OF AMERICA

1/8/1915

of the

Investment Corporation
of the United States

2/15/15

1915

and a non-liquid

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|---|---|---|------|---|------|---|---|
| <div>07334</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>07329</div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5-23-69 | | | 2b. HOUR
1912:40pm |
| George | | | N | | | Fuqua | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
lost birthday) | IF UNDER 1 YEAR
MONTHS | DAYS | IF UNDER 24 HRS
HOURS | MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year | 2d. HOUR |
| Male | White | Feb. 11, 1914 | 55 YRS | | | | | 5 23 69 | 19 2:56pm |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Ky. | | U.S.A. | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| Cheverly | | | Prince George Hospital | | | Salesman | | | Shoe Store |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland | | | Prince George's | | | Marlowe Heights | | | 6110 Dallas Place, #102 |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| George Marvin Fuqua | | | Hanora Burk | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| Yes | | | WW 11 | | | 416 05 7506 Josephine Rich | | | |
| | | | | | | 4009 Gallatin Street
Hyattsville, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u>
955x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
12:40pm 5-23-19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Shot self at home | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
same as #13 | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL
SIGNATURE | | John Kehoe MD Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-24-69 | |
| EXAMINER'S
NAME (Type) | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/28/69 | | Baltimore National | | Baltimore | | Baltimore Md. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JUN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Francis Judge | |
| Francis Gasch's Sons | | | | Hyattsville, Md. | | | | | |

2.1

0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10.0

—

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07335

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07330

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--------------------------|---|--|--|--|------------------------|----------|--|--------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| MORTON WILMORE GALLOWAY | | | | | | Month | Day | Year | 7:20pM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | Nov. 16, 1896 | | 72 YRS. | | MONTHS | DAYS | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington D.C. | | U.S.A. | | | | Prince George Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | Prince George Hospital | | Clerk | | Store | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Md. | | P.G. | | Bladensburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3503 49th Ave. | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Sheridan | | | | | | Mary | | | W. | | Taylor |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | |
| no | | | 577 07 3509 | | | Ella Z Galloway Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> | | | | | | | | | | <u>immediate</u> | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Recent myocardial infarction</u> | | | | | | | | | | <u>2 months</u> | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | <u>year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| <u>Arteriosclerotic massive MI leading to congestive heart failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan Feb 1969</u> to <u>5-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED | | | |
| <u>Donald C. Edgren</u> | | | | | | | | <u>5-8-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| <u>DONALD C. EDGREN</u> | | <u>6201 Springfield Rd. College Park, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 5/10/69 | | Ft. Lincoln | | Colmar Manor P.G. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | DATE | | <u>Charles Judge</u> | | | | | |
| <u>Francis Gasch's Sons Hyattsville, Maryland</u> | | | | | | | | | | | |

1538

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|---|---|--|---|---|
| 07336 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07331 | |
| Item 6 Film 413 6/6/69 kk | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Lena A. Gamble</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>5 30 69</i> | | 2b. HOUR
<i>8:52</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>Negro</i> | 5. DATE OF BIRTH
<i>3/15/05</i> | | 6. AGE (In years lost birthday)
<i>64</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>S.C.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Prince George's Co.</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Cheverly</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>BGGH - ECF</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>At Home</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | 13b. COUNTY
<i>Prince Georges</i> | 13c. CITY OR TOWN
<i>Cedar Heights</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>6412 Lee Place</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Butler Bennett</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Doshier ?</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>579-05-771</i> | 17. INFORMANT Address
<i>Harry Gamble - 6412 Lee Place Cedar Heights, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH CAUSED BY:
<i>1538</i> IMMEDIATE CAUSE (a) <i>Respiratory failure</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Metastatic carcinoma - Primary Colon</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Extensive Metastasis.</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Paraplegia</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 <i>69</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that he (this hospital) attended the deceased from <i>7 May</i> , 19 <i>69</i> , to <i>30 May</i> , 19 <i>69</i> , that he (we) last saw the deceased alive on <i>30 May</i> , 19 <i>69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>30 May 69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>P.C. XAVIER. M.D.</i> | | 22e. ADDRESS
<i>Prince Georges General Hospital - Cheverly, Md.</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
<i>6-5-69</i> | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY
<i>HARMONY</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Highland Park Md</i> | |
| 24. FUNERAL DIRECTOR
<i>H.S. Washington & Sons</i> | | ADDRESS
<i>4925 Deane Ave. NE</i> | | 25a. REC'D BY REGISTRAR
<i>JUN 3 1969</i> | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

38850

4124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 07337 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07332 | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Frances R. Garman | | | | | | 2a. DATE OF DEATH
Month Day Year
May 26 1969 | | 2b. HOUR
5 p. M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Oct. 8, 1889 | | 6. AGE (In years lost in day)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH
Hyattsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Hyattsville Home Nursing 6500 Riggs Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Washington D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3019 Channing St., N.E. | |
| 14. FATHER'S NAME
First Middle Last
Martin Rook | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Nettie Gearheart | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Jay H. Garman Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure
4124 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiovascular Disease 10 yr
(c) Generalized Arteriosclerosis 10 yr | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 wks
10 yr
10 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (1) (this hospital) attended the deceased from March 1969, to 26 May 1969, that (1) (we) last saw the deceased alive on 26 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Wm. D. Wimmer MD | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
26 May 69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
5/27/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor P.G. Md. | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
JUN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Francis Gasch | | | |

07337

RECEIVED

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

TO THE SECRETARY OF AGRICULTURE
FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing agricultural matters, possibly related to plant industry or pest control.]

RECEIVED
[Illegible text in the right margin, possibly a date or reference number.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07338

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07333

| | | | | | | | | | | | |
|---|---------|------------------------------|--|--|------|---|-----------------|---|-----------------------------------|--|----------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Anthony James Garufi | | | | | | Month Day Year | | | 2b. HOUR | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | White | 1-8-1947 | 22 YRS. | MONTHS | DAYS | HOURS | MIN | Month Day Year | 2d. HOUR | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| Washington D. C. | | U. S. A. | | | | | Prince George's | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George Hospital | | | Carpenter | | | Building | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. STREET AND NUMBER | | | | | |
| Maryland | | | Prince George's Rogers Heights | | | 4907 55th. Place | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Henry R. Garufi Sr. | | | Helen C. Carrigan | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | 217 44 4567 | | | Henry R. Garufi Sr. | | | Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Stab wound of chest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
8:30pm 5-17- 1969 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Stabbed during altercation | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
73rd. Ave. and Landover Road, Prince George County, Maryland | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | | | M.D. | | | | 22b. DATE SIGNED | | | |
| John Kehoe MD Riverdale, Md. | | | | | | | | 5-19-69 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 5/21/69 | | Ft. Lincoln | | Colmar Manor P.G. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Francis Gasch's Sons Hyattsville, Md. | | | | | | | | MAY 23 1969 | | Charles Judge | |

07338

STATE OF
NEW YORK

IN SENATE
JANUARY 1, 1903

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 1, 1899

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1903.

THE COMMISSIONERS OF THE LAND OFFICE

ALBANY, N. Y.

1903

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

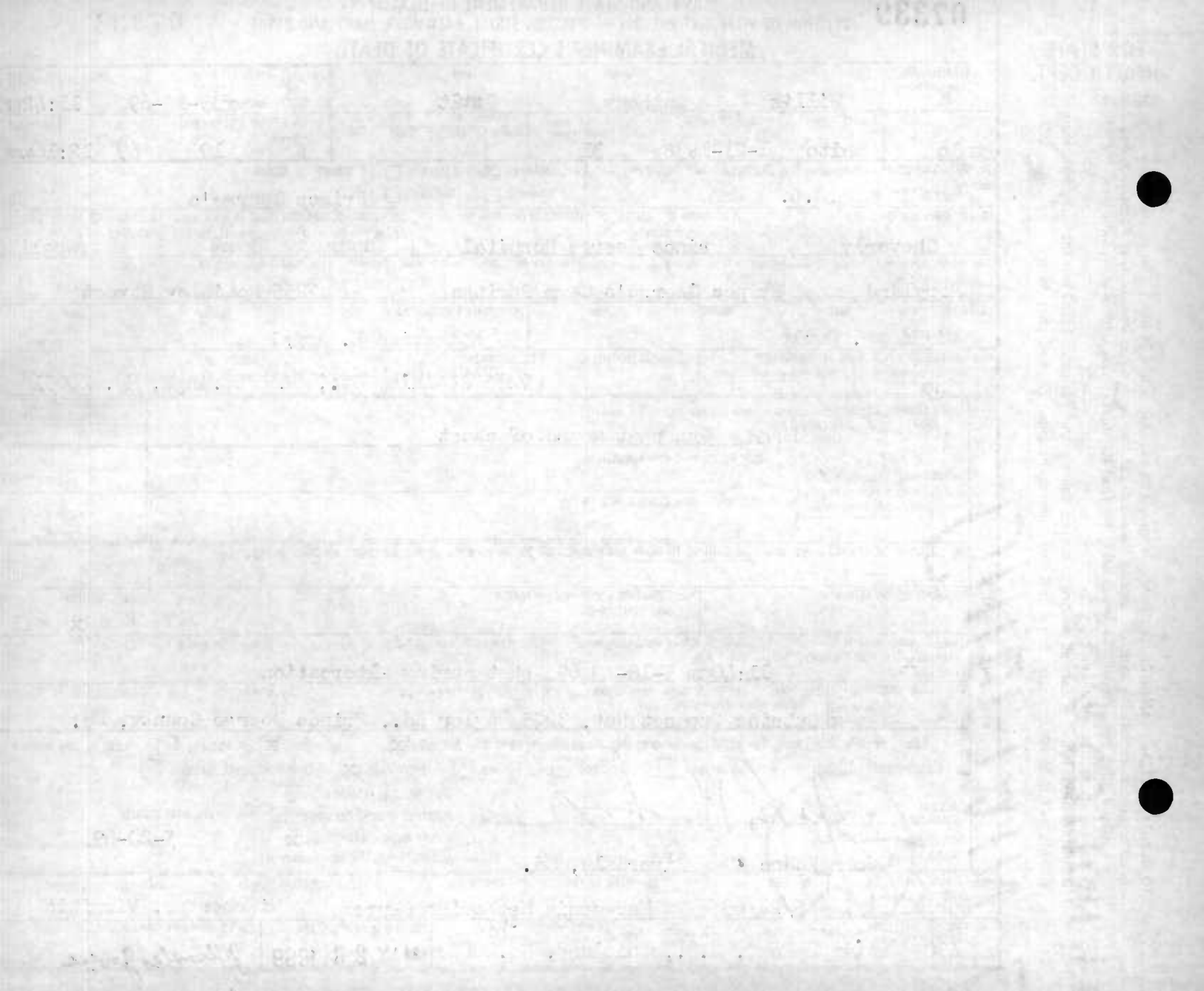
07333

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|---------|--|--|--|------|---|------|--|--|---|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | |
| Willis Anthony Gault | | | | | | Month Day Year | | | | 1911:42pm | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| male | white | 1-21-1938 | 31 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 5 19 69 12:16am | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington, D.C. | | USA | | | | Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George Hospital | | | Insurance Agent | | | Metropolitan | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | Prince George's | | Camp Springs | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7255 McKinley Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Willis M. Gault | | | Katherine L. Arnel | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| no | | | | | | Patricia M. Gault; Wife | | | 7255 McKinley St.; Camp Springs, Md. 20031 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gun shot wound of chest | | | | | | | | | | | |
| 965 X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | 11:40pm 5-18- 19 69 | | shot during altercation | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | Outside Quonset Hut. | | 3225 Naylor Rd., Prince George County, Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | John Kehoe MD Riverdale, Md. | | | | | | | | 22b. DATE SIGNED | |
| | | | | | | | | | | 5-20-69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 5/22/69 | | Macedonia Methodist Church | | Winchester, Virginia | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert E. Wilhelm Funeral Home | | | | 4308 Suitland Road, S.E., Suitland, Md. 20023 | | | | MAY 23 1969 | | Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07340

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07335

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) | | | First
Willie | Middle
John | Last
Gibson | 2a. DATE OF DEATH
Month May , Day 16 , Year 1969 | | | 2b. HOUR
12:50A | | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
10-17-34 | | 6. AGE (In years
last birthday)
34 YRS. | | IF UNDER 1 YEAR
MONTHS | OAYS | IF UNDER 24 HRS.
HOURS | MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gne. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD | | | 13b. COUNTY
Prince George's | | | 13c. CITY OR TOWN
Landover | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
121 82nd Avenue | |
| 14. FATHER'S NAME
Fred Gibson | | | First
Fred | Middle
Gibson | Lost | 15. MOTHER'S MAIDEN NAME
Elivina Gibson | | | First
Elivina | Middle
Gibson | Lost |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
Eloise Gibson 121 - 82nd Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
2910 IMMEDIATE CAUSE (a) Cardio-respiratory arrest due to delirium tremens
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from May 14 , 1969, to May 16 , 1969, that XX (we) lost
saw the deceased alive on May 16 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Guillermo Olivos | | | | | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
MAY 16, 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Guillermo Olivos, M.D. | | | | | | 22e. ADDRESS
Prince George's Gen. Hospital, Cheverly | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
5/19/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem. Park | | | 23d. LOCATION (City or Town) (County) (State)
7601- Sheriff Rd. Md. | | | |
| 24. FUNERAL DIRECTOR
Washington Funeral Chapel | | | | | | ADDRESS
475- H St. N.W. | | 25a. REC'D BY REGISTRAR
MAY 23 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

02870

Washington Bureau dated 4/25/50
May 2 1950
7501 - 27-442-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|--------|---|---|--|--|--|-------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | |
| GRACE D. GOLDENBURG | | | | | MAY 13, 1969 | | | 7P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| FEMALE | | CAUCASIAN | | JULY 19, 1880 | | 88 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| KENTUCKY | | U.S. | | | | PRINCE GEORGE'S Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| GREENBELT | | GREENBELT CONVALESCENT CENTER | | HOUSEWIFE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | PRINCE GEORGE'S | | SEABROOK | | | | 9404 VAN BUREN | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| DANIEL | | | | DELANEY | FLORENCE | | | | MANBY |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | UNKNOWN | | MRS VIRGINIA. KAECHER | | SAMPAS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
4409 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized arteriosclerosis.</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1969</u> , to <u>May 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Dow B. Cameron</u> | | | | 22c. DATE SIGNED
<u>May 14, 1969</u> | | 22d. PHYSICIAN'S NAME (Type)
<u>DOW B. CAMERON</u> | | | |
| 22e. ADDRESS
<u>MT. RAINIER, MARYLAND.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 17 MAY 1969 | | SPRING GROVE CEM | | CINCINNATI, OHIO | | | |
| 24. FUNERAL DIRECTOR
<u>W.W. CHAMBERS Co. RIVERDALE, MD.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 19 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07342

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07337

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) EDITH EVELYN GORRICK | | | 2a. DATE OF DEATH
Month MAY Day 12 Year 1969 | | | 2b. HOUR
M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
JULY 8, 1900 | | 6. AGE (In years last birthday)
68 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Brit Ind | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGE Md. | |
| 10. CITY OR TOWN OF DEATH
RIVERDALE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
LELAND MEM. HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
LAUREL | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
15401 ALAN DRIVE | | 14. FATHER'S NAME
First O'Donnell Middle O'Donnell Last O'Donnell | | 15. MOTHER'S MAIDEN NAME
First Leleig Middle Troupe Last Troupe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
4109 | | 17. INFORMANT
Laurie J. Gorrick, Laurel Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-27, 1968 , to 5-12, 1969 , that (I) (we) lost saw the deceased alive on 5-12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Fernando de la Torre MD | | | | 22c. DATE SIGNED
5-16-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
G. A. de la Torre MD | | | | 22e. ADDRESS
320 Montgomery St. Laurel Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
May 16, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Landow Park | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Donald Dean Funeral Home Laurel Md | | | | 25a. REC'D BY REGISTRAR
MAY 22 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

4109
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|
| 07343 CERTIFICATE OF DEATH 07338 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Minnie D. Goss | | | 2a. DATE OF DEATH Month Day Year
5 23 69 | | | 2b. HOUR
11 15 M | | | |
| 3. SEX
F | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
01/25/88 | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Vermont | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH
Adelphi | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1801-Metzerott Manor Care, Adelphi Rd. | | | 12a. USUAL OCCUPATION (Kind of work done at most of working life, even if retired.)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Va. | | 13b. COUNTY
Arlington | | 13c. CITY OR TOWN
N.A. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
5302-Little Falls Rd. | |
| 14. FATHER'S NAME First Middle Last
Joseph A. DeBoer | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Augusta A. Featherley | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
025-20-3845 | | 17. INFORMANT Address
1801-Metzerott Rd.-Adelphi, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Failure -</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerotic Cardiovascular Disease</u>
15 minutes
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Bronchial Asthma</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-20-1969</u> , to <u>5-28-1969</u> , that (I) (we) last saw the deceased alive on <u>5-20-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Morton Altschuler, M.D.</u> | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5-28-69</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Morton Altschuler, M.D.</u> | | | | 22e. ADDRESS
<u>9205-New Hampshire Ave. Spring, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
May 28, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR
Ives Funeral Home | | | | ADDRESS
2847 Wilson Blvd., Arlington, Virginia | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|-------------------------|--|---|--|--|
| 07344 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07339 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Paul D. Griga | | | 2a. DATE OF DEATH
Month 5 Day 25 Year 69 | | 2b. HOUR
6:28 PM |
| 3. SEX
male | 4. RACE
white | | 5. DATE OF BIRTH
12/18/1902 | | 6. AGE (In years last birthday)
66 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince Georges Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman | 12b. KIND OF BUSINESS OR INDUSTRY
Retail |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
PG | 13c. CITY OR TOWN
Camp Springs | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
7819 Coolridge Drive |
| 14. FATHER'S NAME First Middle Last
Daniel Griga | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Augusta Recklies | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
578-38-7265 | | 17. INFORMANT Address
Miss Linda Griga, Daughter 7819 Coolridge Drive, Camp Springs, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden death, presumed myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive cardiovascular disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) 4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15+ years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to May , 19 69 , that (I) (we) last saw the deceased alive on 1 May 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard M. Huffman, M.D. | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/26/69 |
| 22d. PHYSICIAN'S NAME (Type)
Richard M. Huffman, M.D. | | | 22e. ADDRESS
2001 Eye St. N.W. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
5/28/69 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home | | | 25a. REC'D BY REGISTRAR
JOHN A 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

01389

22-00-23

July

19

1967

Prince Georges
white
also

[Faint, mostly illegible handwritten notes and markings, possibly including a signature or large scribble.]

01389

2001 00 22 1967

Prince Georges, N.B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---|--|-----------------------------|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 07345 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07340 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Earl Thomas Grubbs | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
May 20, 1969 | | | | | | | | | | 2b. HOUR P
4:55M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
Caucasion | | | 5. DATE OF BIRTH
Feb. 6, 1917 | | | 6. AGE (In years last birthday)
52 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Va. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Prince Georges Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Riverdale | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
E. Leland Mem. Hosp. | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | | 13b. COUNTY
P.G. | | | | | 13c. CITY OR TOWN
Hyattsville | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
7719 Garrison Rd. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Leon T. Grubbs | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Loula Ann Slagle | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes | | | | | 16b. SOCIAL SECURITY NO.
WW 11 218 54 7272 | | | | | 17. INFORMANT Address
Evelyn M. Grubbs Same as #13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ACUTE MYOCARDIAL INFARCTION</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ACUTE PNEUMONITIS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 18 DAYS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-3</u> , 19 <u>69</u> , to <u>5-20</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-20</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>(did)</u> (did not) view the body after death. | | | | | | | | | | | | | | | 22b. SIGNATURE <u>C. J. Houmann</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED <u>5-20-69</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN M.D.</u> | | | | | | | | | | | | | | | 22e. ADDRESS <u>RIVERDALE MD.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | | | | | | 23b. DATE
5/23/69 | | | | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | | | | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor P.G. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | ADDRESS
Francis Gasch's Sons Hyattsville, Md. | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE
MAY 23 1969 | | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |

013343

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK
IN SENATE
January 10, 1917
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1916
ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1917

1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|----------------|---|--------------|--|--------------|
| 07346 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07341 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Susan | Middle
Ellen | Lost
Gunn | 2a. DATE OF DEATH
Month
May | |
| | | | | | | Day
20 | Year
1969 |
| | | | | | | 2b. HOUR
4:45 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
02-22-95 | | 6. AGE (In years
last birthday)
74 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
MD | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Glen Dale | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
Daisy Lane | | 14. FATHER'S NAME
First
Owen | | 15. MOTHER'S MAIDEN NAME
First
Emily | | 15. MOTHER'S MAIDEN NAME
Middle
Martin | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
Yes | | 16b. SOCIAL SECURITY NO.
WW 1 | | 17. INFORMANT
Josephine C. Probst | | 17. INFORMANT
Address
Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic malignancy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of the pancreas</u>
1579
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Diabetes mellitus</u> | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
15 minutes
months
months | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
Yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>69</u> , to <u>5/20</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>5/19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>David M. Goldman MD</u> | | | | DEGREE
ATTENDING
PHYS. | | 22c. DATE SIGNED
<u>5/20/69</u> | |
| 22d. PHYSICIAN'S
NAME (Type)
David M. Goldman, M.D. | | | | 22e. ADDRESS
Suite 100 Center Building Hyattsville | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington Arlington Va. | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 23 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

07348

REPUBLIC OF CHINA

DATE: 1957-12-12

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

REFERENCE: [illegible]

REMARKS: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

7769
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 07347 | | | | | | | | | | |
| Items #14, 15, taken from birth certificate | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 07342 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| Baby | | | Boy | | | Hamilton | | May 15 1969 12:35P | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | White | | 05-15-69 | | YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| USA | | | | | | Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George's Gen. Hosp. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | Prince George's | | Hyattsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2007 Ogleshome | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| Richard Anthony Hamilton, Jr. | | | Charlotte Lee McWhorter | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Imaturity</u>
<u>7769</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Atelectasis Neonatorum</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 15</u> , 19 <u>69</u> to <u>May 15, 1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>May 15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>May 15-1969</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Hugh Clark, M.D.</u> | | | | | 22e. ADDRESS
<u>7309 Riggs Road - Hyattsville</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | 5-24-69 | | Prince George's Gen. Hosp. | | Cheverly, Prince Georges, Md. | | | | |
| 24. FUNERAL DIRECTOR
<u>Harry W. Penn, Jr., Administrator</u> | | | | | 25a. REC'D BY REGISTRAR
<u>May 28 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

07347

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 10, 1910

Dear Sir:

Very

Thank you for your letter of January 8, 1910.

-15-04

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages land 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|-------------------------|---|---|--|--|
| 07349 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07344 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Clarence Robert Hazelrigg | | | 2a. DATE OF DEATH
Month Day Year
May 15, 1969 | | 2b. HOUR
3:40 A M |
| 3. SEX
Male | 4. RACE
White | | 5. DATE OF BIRTH
Sept. 5, 1899 | | 6. AGE (In years lost birthday)
69 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George Md. |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret. Book Binder | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
P. G. | 13c. CITY OR TOWN
District Heights | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
2118 County Rd. Apt. #1 |
| 14. FATHER'S NAME First Middle Last
Henry F. Hazelrigg | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Martha A. Christensen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes WW 1 | | 16b. SOCIAL SECURITY NO.
329 01 2500 | | 17. INFORMANT
Address
Lura A. Hazelrigg Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrhythmia
4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) ASHD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
15-20 min | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Emphysema | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 1968 , to 5/15, 1969 , that (I) (we) last saw the deceased alive on 5/8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Charles F. Colao | | | | 22c. DATE SIGNED
5/15/69 | |
| 22d. PHYSICIAN'S NAME (Type)
Charles F. Colao | | | | 22e. ADDRESS
1630 Minnesota Ave SE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/19/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Graceland Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Decatur Machon Illinois | | 24. FUNERAL DIRECTOR
ADDRESS
Francis Gasch's Sons Hyattsville, Md. | | | |
| 25a. REC'D BY REGISTRAR
DATE
MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

2350

197350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07345

| | | | | | | | | | | | | |
|--|--|--|--|--|---|---|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
Icie | Middle
T. | Last
Heartley | 2a. DATE OF DEATH
Month Day Year
May 7 1969 | | | 2b. HOUR
4:04P ^M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
01-30-05 | | 6. AGE (In years
last birthday)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gen. Hop. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
MD | | | 13b. COUNTY
Prince George's | | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4910 Talbot Ave. | | |
| 14. FATHER'S NAME
First Middle Last
Philmore Croson | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Annie Saffer | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) (If yes give war or dates of service)
no | | | 16b. SOCIAL SECURITY NO.
579 05 9834 | | | 17. INFORMANT
Address
William Henry Heartley Sr. Same as # 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Chumkosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral Ischemia</u>
CONDITIONS, IF ANY, WHICH GAVE
RISE TO IMMEDIATE CAUSE (a),
STATING THE UNDERLYING CAUSE
LAST. | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
one day
5 years
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1965, to May 1969, that (I) (we) last
saw the deceased alive on 4-25-1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
D. S. AHAKIAN | | | | | | DEGREE
ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | | | 22e. ADDRESS
5001 Landover Rd. Clarks Md. | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
5/10/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor P.G. Md. | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Francis Gasch's Sons Hyattsville, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 12 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

017350

STATE OF TEXAS

County of _____
City of _____
I, _____, County Clerk of said County, do hereby certify that _____
is the true and correct copy of the _____
as the same appears from the _____
of said _____.

Witness my hand and the seal of said County, this _____ day of _____, 19____.

County Clerk

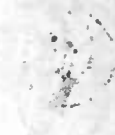
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1013. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|--|---|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF DEATH | | | 2b. HOUR |
| Richard Hendricks | | | | | | 5-18-69 10:50pm | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Male | White | 5-8-1916 | 53 YRS. | | | | | 5 18 69 11:03pm | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Indiana | | USA | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Riverdale | | | Leland Memorial Hospital | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| Maryland | | | Prince George's | | | Hyattsville | | | 6700 Bellcrest Road |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes
over 5 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Diabetes - over 5 yrs.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 5-19-69 | | | |
| John Kehoe MD | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| Riverdale, Maryland | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Removal | | | 5/21/1969 | | Anatomical Board of Md. | | Baltimore Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Chambers Funeral Home Hyattsville, Maryland | | | | | MAY 26 1969 | | J. Charles Judge | | |

18750
AMERICAN AIRWAYS EXPEDITE OF DEATH



4109
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07352 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07347 | | | |
|--|--|--|-------------|---|---|---|--|---|--|--|--|
| Item 13 Film 413 6/9/69 kk | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
Minnie | Middle
A | Last
Hillmuth | 2a. DATE OF DEATH
Month Day Year
May 27, 1969 | | | 2b. HOUR
7:40P M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
02-10-82 | | 6. AGE (In years
last birthday)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gen. Hosp | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Lanham | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7611 23rd Avenue
Magnolia Gardens Nursery Home | | | |
| 14. FATHER'S NAME
First Middle Last
ROBERT ALEXANDER | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARY LOUISE TAYLOR | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
MRS LOUISE WIMPEE 6831D RIVERDALE RD
RIVERDALE, MD 20840 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Severe coronary arteriosclerosis with occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF <u>right</u>
(b) <u>Senility</u> <u>arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Several yrs</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-2</u> , 1967, to <u>5-27</u> , 1969, that (I) (we) last
saw the deceased alive on <u>5-27-69</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Leon Levitsky</u> | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-28-69 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Leon Levitsky, M.D. | | | | 22e. ADDRESS
3408 Rhode Island Ave. Mt Rainier | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
5-31-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
WASHINGTON NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
SUITLAND MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
C.W. CHAMBERS CO RIVERDALE, MD | | | | 25a. REC'D BY REGISTRAR
DATE JUN 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

0350

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

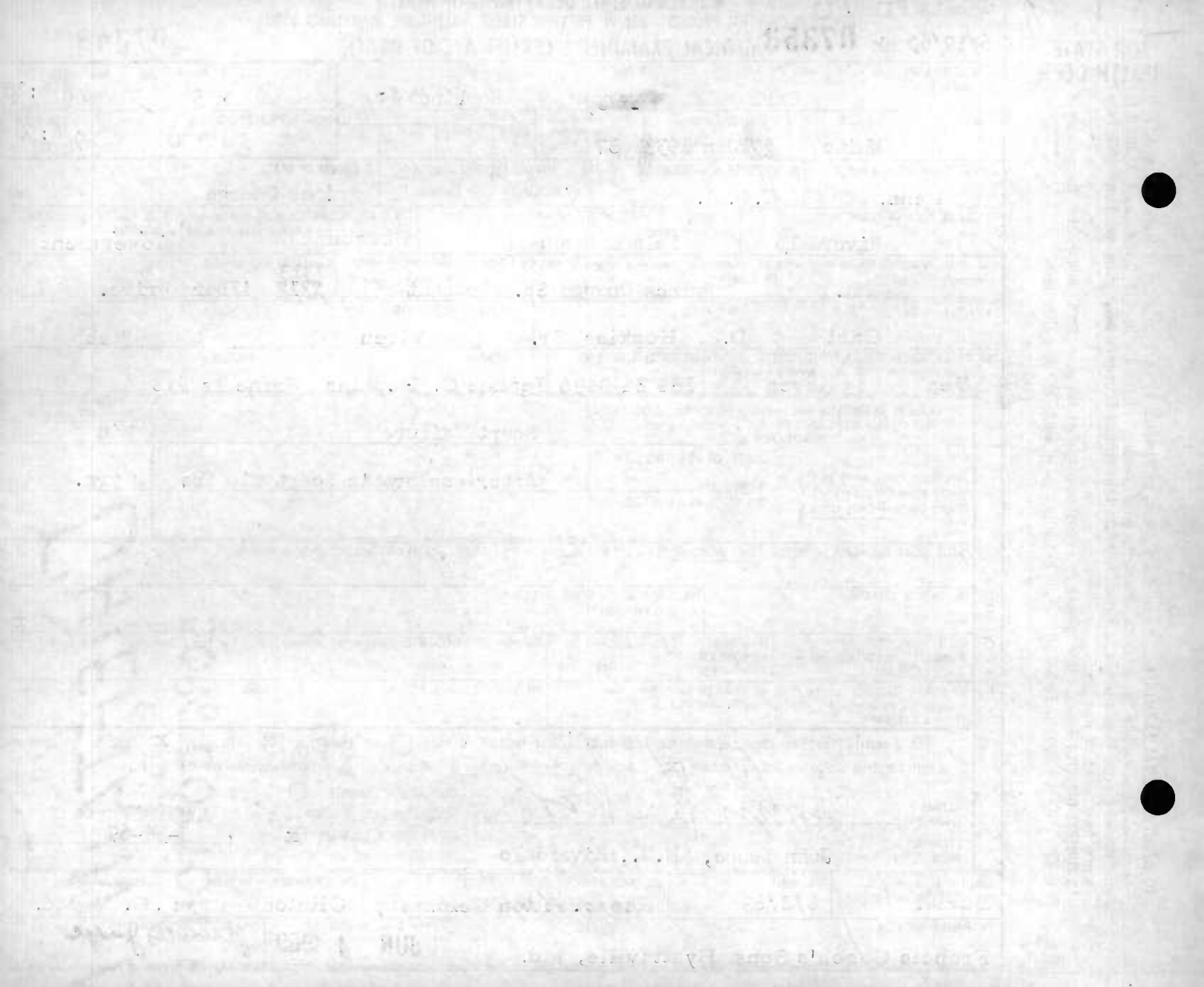
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 13 Film 113
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
6/19/69 kk 07353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07348

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|---|--|-----------------------------|--|-------|--|-------------------|--|------|--|-------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN
OF DEATH | | Month | | Day | | Year | | 2b. HOUR
a. m. | | | | | |
| Carl Dewey Hopkins Jr | | | | | | | | 25 | | 30 | | 19 | | 69 | | 6:20 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | Month | | Day | | Year | | 2d. HOUR
a. m. | |
| M | | White | | 22 Jan 1932 | | 37 YRS | | MONTHS | | DAYS | | 5 | | 30 | | 19 | | 69 | | 6:50 | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | | | | | | | | | |
| Penn. | | U. S. A. | | WIDOWED | | DIVORCED | | Prince George | | | | | | | | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | |
| Riverdale | | Leland Hospital | | Personal | | Government | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | | | | | | | |
| Md. | | Prince George St. | | Pleasant | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 7317 Wilburn Drive. | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | | | | | | | |
| Carl D. Hopkins Sr | | | | | | | | Viven Webb | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| Yes | | Koren | | 184 24 0496 | | Jeanne C. Hopkins | | Same as #13 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | 4123 | | Heart failure | | Min | | 8 yrs. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | John Kehoe | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-30-69 | | | | | | | | | |
| EXAMINER'S
NAME (Type) | | John Kehoe, M.D., Riverdale | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | |
| Burial | | 6/2/69 | | Resurrection Cemetery | | Clinton P. G. Md. | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Francis Gasch's Sons | | Hyattsville, Md. | | JUN 4 1969 | | Francis Gasch's Sons | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07354 CERTIFICATE OF DEATH 07349 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Mary | | | First Middle Last L. Jackson | | | 2a. DATE OF DEATH
Month Day Year May 30, 1969 | | | 2b. HOUR
P. M. 2:00 P. |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
3/10/1922 | | | 6. AGE (in years last birthday)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Washington D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH
Glenn Dale | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Glenn Dale Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Domestic | | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1322 Stevens Road S.E. | |
| 14. FATHER'S NAME
First Middle Last
Samuel Jackson | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Annie Tolson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)
None | | 16b. SOCIAL SECURITY NO.
577-24-9474 | | 17. INFORMANT
Decedent Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Disseminated lupus erythematosus with extensive vasculitis.
7341
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs. 5 mos | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes mellitus secondary to corticosteroid administration. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 12/28/1966 , to 5/30/1969 , that (X) (we) last saw the deceased alive on 5/30/1969 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William J. Washington, Jr. MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
May 30, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
William J. Washington, Jr., M.D. | | | | | | 22e. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
6-6-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial | | | 23d. LOCATION (City or Town) (County) (State)
Suitland Md | | |
| 24. FUNERAL DIRECTOR
H. S. Womack ADDRESS
4925 Doner One NE | | | | | | 25a. REG. DAY REGISTERED
JUN 3 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

39010746

A. B. U.

2000

Washington

1997, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1992-1993

432151

1993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|---------|--|------------------|---|----------------------------|---|--------------------------------|--|-------|
| 07355 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07350 | | | |
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Bernard | | | | Jenkins | 5 Month 20 Day 69 Year | | 10:45a M | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | white | | 3/17/1900 | | 69 YRS. | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | USA | | | | Prince George Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. INDUSTRY OR BUSINESS OR | | | |
| Riverdale | | Eugene Leland Memorial | | Maintenance | | Hyattsville | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Prince George | | Hyattsville | | | | 4217 Jefferson St. | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Eastham | | | | Jenkins | Mary | | L. | | Leake |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| no | | 578 03 5776 | | Spouse and | | Medical Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) | | 4109 | | DUE TO, OR AS A CONSEQUENCE OF | | ACUTE MYOCARDIAL INFARCTION | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
18 DAYS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | ATHEROSCLEROTIC CORONARY ARTERY DISEASE | | UNKNOWN | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-2-1969, to 5-20-1969, that (I) (we) lost the deceased alive on 5-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | C. J. HOUHANN | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
20 MAY 69 | |
| 22d. PHYSICIAN'S NAME (Type) | | C. J. HOUHANN M.D. | | 22e. ADDRESS | | RIVERDALE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/23/69 | | Wood Bine Cemetery | | Harrisonburg Va. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. RECD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis Gasch's Sons | | Hyattsville, Md. | | MAY 23 1969 | | Charles Judge | | | |

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RECORD OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|---|---|---|--|---|--------------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07351 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Eagle | | | P. | | Johnson | Month 5 Day 30 Year 69 | | | 2:50 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| M | | W | | 12/20/94 | | 74 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Virginia | | U.S.A. | | | | Prince Georges | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Adelphi | | | Manor Care
1801 Monroeville Rd Adelphi | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| D. C. | | | | | | | 4913 N.W. Ave N.W. | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First Middle Lost | |
| Robert | | | | | Johnson | Martha Jane | | | Smith | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | |
| No | | | 677-42-5174 | | Mrs. Kitty Johnson | | | | 4912 N.H. Ave. N.W. D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebrovascular disease</u>
437.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>10gr.</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 mo.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
XXXXXX NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>24 April</u> , 19 <u>69</u> , to <u>30 May</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>30 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>William A. Wimsatt MD</u> | | | | | 22c. DATE SIGNED
<u>30 May 69</u> | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) William A. Wimsatt | | | | | 22e. ADDRESS
3415 Hamilton Avenue Hyattsville, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 6-3-69 | | Riverview Cemetery | | Charlottesville Virginia | | | | |
| 24. FUNERAL DIRECTOR <u>Monroe Collins</u> | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 500 University Blvd W Silver Spring Md | | | | | JUN 5 1969 | | <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 07357 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07352 | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| Ora B Johnson | | | | | | Month 5 Day 18 Year 69 | | 2 45 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | Caucasian | | 8-12-92 | | 767-7 YRS. | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Kentucky | | USA | | | | Prince George Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| HYATTSVILLE | | HYATTSVILLE Nsg Home | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Pr. Geo. | | Brentwood | | | | 3605 Varnum St. | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| (Unknown) | | Belle Mercer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMATION Address | | | | | |
| | | | | U Conner, RN 2113 Guilford Rd, Hyattsville Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive Heart Failure | | | | | | | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to 5-18, 1969, that (I) (we) lost the deceased on 5-18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Walter Kramer | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 5/18/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS 8484-16th St. 88-Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/21/1969 | | Ft. Lincoln Cem. | | Colmar Manor, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Nalley's Funeral Home Inc. | | | | Mt. Rainier, Maryland | | MAY 23 1969 | | Charles Judge | |

07357

CERTIFICATE OF DEATH

DEATH OF A PERSON WHOSE NAME IS NOT KNOWN

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF INTERVIEWER: [illegible]

NAME OF WITNESS: [illegible]

NAME OF CLERK: [illegible]

NAME OF REGISTRAR: [illegible]

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

NAME OF FUNERAL HOME: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
Vincent | | | First Pierre Middle Mary Last Jones | | | 2a. DATE OF DEATH
Month 5 Day 23 Year 69 | | | 2b. HOUR
7:11 PM | | |
| 3. SEX
Male | | | 4. RACE
colored | | | 5. DATE OF BIRTH
May 23, 1969 | | | 6. AGE (In years last birthday)
YRS. — MONTHS — DAYS — HOURS — MIN. 49 | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Prince Georges Co. | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince Georges Gen. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Prince George's | | | 13c. CITY OR TOWN
Upper Marlboro | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER
P.O. Box 128 | | | 14. FATHER'S NAME First Marvin Middle Vincent Last Jones | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Ella Last Morris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Premature baby -
7701
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Premature labor -
DUE TO, OR AS A CONSEQUENCE OF
(c) Anruptio Placenta - | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 23, 1969 , to MAY 23, 1969 , that (I) (we) lost saw the deceased alive on MAY 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Scartascini | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
RICARDO SCARTASCINI | | | 22e. ADDRESS
Prince George's Gen. Hospital | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
6/7/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Prince Geo. General Hospital | | | 23d. LOCATION (City or Town) (County) (State)
Cheverly, Maryland | | |
| 24. FUNERAL DIRECTOR
Harry W. Penn, Jr., Administrator | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
JUN 10 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

SECRET



4489

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|----------------|---|--------------------|---|--|
| 07359 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07353 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Marie | Middle
A | Last
Joyce | 2a. DATE OF DEATH
Month
May | |
| | | | Day
30 | Year
1969 | 2b. HOUR
2:50 M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
February 8, 1882 | | 6. AGE (In years
last birthday)
87 YRS. | |
| | | | | | | IF UNDER 1 YEAR
MONTHS
OAYS
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George Md. | |
| 10. CITY OR TOWN OF DEATH
Hyattsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Sacred Heart Home | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
at home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
District of Columbia | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
1959 - 39th Street, N.W. | | 14. FATHER'S NAME
First
Joseph | | 15. MOTHER'S MAIDEN NAME
First
Anna | | 15. MOTHER'S MAIDEN NAME
Middle
Germaceau | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
579-62-7801 | | 17. INFORMANT
Address
Sacred Heart Home, Hyattsville, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>
<u>4123</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) <u>Generalized Arteriosclerosis & Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>years</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>67</u> , to <u>5/30</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>3/17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>John W Winkler Jr MD</u> | | | | DEGREE
ATTENDING
PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S
NAME (Type)
JOHN W WINKLER JR | | | | 22c. DATE SIGNED
<u>5/30/69</u> | | | |
| 22e. ADDRESS
<u>5800 10th PL
HYATTSTVILLE, MD.</u> | | | | | | | |
| 23a. BURIAL CREMATION,
REMOVAL (Specify) | | 23b. DATE
<u>6-4-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington D.C.</u> | |
| 24. FUNERAL DIRECTOR
<u>W. W. Chambers Co. 517-11th St. S.E.</u> | | | | 25a. REC'D BY REGISTRAR
DATE
<u>JUN 5 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 07360 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07354 | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
MARY C KEATINGE | | | | | | 2a. DATE OF DEATH
Month Day Year
5 22 69 | | 2b. HOUR
5.10 A M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASION | | 5. DATE OF BIRTH
5-4-88 | | 6. AGE (In years
last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
D C | | 7b. CITIZEN OF WHAT COUNTRY?
AMERICA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGES COUNTY Md. | | | |
| 10. CITY OR TOWN OF DEATH
FORESTVILLE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
REKENT NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
RETIRED | | 12b. KIND OF BUSINESS OR
INDUSTRY
COMMUNICAT | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
MARYLAND | | 13b. COUNTY
PRINCE GEORGES | | 13c. CITY OR TOWN
FORESTVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3438 LORRING DRIVE. | |
| 14. FATHER'S NAME
First Middle Last
Michael J. Hurley | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Nay Lanahan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
578-44 1318A | | 17. INFORMANT
D. J. Keating, Son | | Address
3438 Lorrington Drive, Forestville, Md. 20028 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
4123 DUE TO, OR AS A CONSEQUENCE OF
Coronary Insufficiency
(b)
DUE TO, OR AS A CONSEQUENCE OF
Chronic Heart Disease
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerosis cerebrovascular disease cerebral thrombosis Hemiplegia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-17-1969, to 5-22-1969, that (I) (we) lost
saw the deceased alive on 5-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Oliver B. Bond | | | | 22c. DATE SIGNED
5-22-69 | | 22d. PHYSICIAN'S
NAME (Type)
OLIVER, B. BOND | | | |
| 22e. ADDRESS
7420 MARLBORO PIKE
FORESTVILLE MARYLAND 20028 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5/24/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home | | | | 25a. REC'D BY REGISTRAR
MAY 27 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| Nathaniel | | | -- | | King | | | | May 6 1969 | | 10: p M | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | | Negro | | | 10/22 /19 | | | 49 YRS. | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| North Carolina | | | USA | | | | | | Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Glenn Dale, Maryland | | | Glenn Dale Hospital | | | Laborer | | | -- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| N | | | | | | Wash., D.C. | | | | 313 Oakdale Street, N.W. | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | |
| Louis | | | King | | | | | | Louise Love | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | |
| No | | | 244-10-7055 | | | Decedent | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung, with metastases
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mos. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary tuberculosis. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (x) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>68</u> , to <u>5/6</u> , 19 <u>69</u> , that (x) (we) lost saw the deceased alive on <u>5/6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (not see) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Moe Weiss</i> | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/6/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | | | | | 22e. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | 23b. DATE
4/4/69 | | 23c. NAME OF CEMETERY OR CREMATORY
ANATOMICAL BOARD | | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. <i>Chur.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Carl F. Oupert</i> | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles</i> | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07362

CERTIFICATE OF DEATH

07356

| | | | | | | | |
|---|--|---|--------|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
<i>Twin 1</i> | | First | Middle | Last
<i>KOSH</i> | 2a. DATE OF DEATH
Month <i>May</i> Day <i>10</i> Year <i>1969</i> | | 2b. HOUR
<i>10:30</i> |
| 3. SEX
<i>female</i> | | 4. RACE
<i>colored</i> | | 5. DATE OF BIRTH
<i>May 9 1969</i> | | 6. AGE (In years lost birthday)
YRS. <i>—</i> MONTHS <i>1</i> DAYS <i>24</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Prince George's</i> Md. | |
| 10. CITY OR TOWN
<i>Cheverly</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Prince George's Gen. Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Prince George</i> | | 13c. CITY OR TOWN
<i>Laurel</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
<i>unmarried</i> | | 15. MOTHER'S MAIDEN NAME
<i>Thelma Kosh</i> | | 13e. STREET AND NUMBER
<i>100 9th St</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Thelma Kosh</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Prematurity</i>
<i>777X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from <i>MAY 5</i> , 19 <i>69</i> , to <i>MAY 10</i> , 19 <i>69</i> , that (H) (we) last saw the deceased alive on <i>MAY 10</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Hugh G Clark</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYS.
<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>May 10 1969</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Hugh G Clark</i> | | 22e. ADDRESS
<i>7309 Riggs Road Hyattsville, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Cremation</i> | | 23b. DATE
<i>5-17-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Pr. George's General Hosp.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Cheverly, Prince George's, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Harry W. Penn, Jr., Administrator</i> | | ADDRESS | | 25a. REC'D BY REGISTRAR
<i>Charles J. J...</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. J...</i> | |

OFFICE OF THE SECRETARY

1051

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Baby Boy "B" Middle Kosh Last | | | 2a. DATE OF DEATH
Month May Day 9, Year 1969 | | 2b. HOUR
9:10P M | |
| 3. SEX
male | | 4. RACE
colored | | 5. DATE OF BIRTH
May 9, 1969 | | 6. AGE (In years last birthday)
YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of last year if retired.)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Maryland | | 13b. CITY OR TOWN
Prince George's | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
100 9th street | |
| 14. FATHER'S NAME
unmarried | | | 15. MOTHER'S MAIDEN NAME
The lma Kosh | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity (1st. 70%)</u> <u>Twin</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 5</u> , 19 <u>69</u> , to <u>MAY 9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>MAY 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Hugh G. Clark</u> | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Hugh G. Clark | | | | | | 22e. ADDRESS
7309 Riggs Road Hyattsville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
5-16-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Prince George's Gen. Hosp. Cheverly, Prince George's, Md. | | 23d. LOCATION (City or Town) (County) (State) | | | |
| 24. FUNERAL DIRECTOR
Harry W. Penn, Jr., Administrator | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAY 22 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

87363

CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|------------------------|--|------------------------|--|
| Name of deceased | | Date of birth | | Sex | |
| John Doe | | Jan 1, 1900 | | Male | |
| Place of birth | | Date of death | | Cause of death | |
| New York City | | Jan 15, 1950 | | Heart disease | |
| Usual residence | | Occupation | | Manner of death | |
| 123 Main St, New York | | Teacher | | Natural | |
| Physician | | Burial place | | Burial date | |
| Dr. Smith | | Cemetery | | Jan 20, 1950 | |
| Signature of physician | | Signature of registrar | | Signature of informant | |
| [Signature] | | [Signature] | | [Signature] | |
| Date of certificate | | Place of issue | | Official use | |
| Jan 18, 1950 | | New York City | | [Seal] | |

4124
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07364

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07358

| | | | | | | | | | | |
|---|--|--|--------------|---|--|---|--|--|--------------------------|-------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First
Martha | Middle
E. | Last
Kraft | 2a. DATE OF DEATH
Month
May | | Day
10 | Year
1969 | 2b. HOUR
A
10:15 M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
9/25/83 | | 6. AGE (In years
last birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gen. Hosp | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
None | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. CITY OR TOWN
Prince George's St. Pleasant | | 13c. CITY OR TOWN
St. Pleasant | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6708 F St. | | |
| 14. FATHER'S NAME
First
Henry | | Middle
- | | Last
Jeter | | 15. MOTHER'S MAIDEN NAME
First
Sara | | Middle
R | | Last
Rankin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Paul E. Kraft 6900 C St Seat Pleasant | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>
<u>4124</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Arteriosclerotic cardiovascular disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>10 years</u>
<u>10 years</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (we) attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>5-10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Peter Duus, M.D.</u> | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR
<input type="checkbox"/> | | STAFF PHYS.
<input type="checkbox"/> | | 22c. DATE SIGNED
5/10/69 |
| 22d. PHYSICIAN'S NAME (Type)
Peter Duus, M.D. | | 22e. ADDRESS
6056 Central Ave., Capitol Hgts., Md. | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5-13-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | | 23d. LOCATION (City or Town)
Washington | | (County)
D. C. | | (State) |
| 24. FUNERAL DIRECTOR
<u>Robert E. Wilhelm</u> | | 24b. ADDRESS
<u>308 Spittland Road</u> | | 24c. CITY OR TOWN
<u>Baltimore Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE
MAY 14 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

07304



RECEIVED
JAN 10 1964

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5/29/69 **DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

07365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07359

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5-18-69 | | 2b. HOUR
19 4:20pm | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
10-21-1950 | | 6. AGE (In years
last birthday)
18 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
5 18 69 19 6:35pm M | |
| 7a. BIRTHPLACE (State or foreign
country) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Suitland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Andrews Air Force Base Hosp/ | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Camp Springs | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7104 Pleasant Hill Drive | | | |
| 14. FATHER'S NAME
First Middle Last
William D. Langston | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Marion M Lintz | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Father | | ADDRESS
Same as 13 abcde | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Electrocution</u>
<u>9258</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
4:15pm 5-18-1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
Climbed utility pole | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
grounds of Crossland High School, Prince George County, Md. | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) John Kehoe MD Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
5-19-69 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5-22nd 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Resurrection | | 23d. LOCATION (City or Town) (County) (State)
Clinton Pr. George Md | | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Mittingley | | | | ADDRESS 131 11th
st S.E.D. | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

72550

1964 JAN 24 AM 10 45

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed ~~within 24~~ hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ~~FD-302~~ Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07360

VR A15ME (5)
10M REV. 1/68

07386 ON ON LONDON, LONDON, LONDON

FOR THE
THE



FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health (prior to burial, cremation, or removal, and in any event within 72 hours after death)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07367

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07361

| | | | | | | | | | | |
|---|---------|---|------------------------------------|---|----------------------------|---|-------|---|------|-----------------------------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF DEATH | | Month | Day | Year | 2b. HOUR
am |
| Lewis | | Lee | Leatherman | | 5 | | 16 | 19 | 69 | 8:55 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS | DAYS | IF UNDER 24 HRS.
HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| M | W | 10 Aug 1908 | 60 YRS. | | | | | Month 5 Day 16 Year 19 69 | | 9:50 |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Prince George | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| Cheverly | | Prince George Hosp | | Machinest | | None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md | | Prince George | | Hillside | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1404 51st Ave. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS |
| Emory Leatherman | | Annie Heerd | | No | | 579-09-9255 | | Mrs. Anna M. Leatherman | | Braddock Hgts. Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Over 6 mos.</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | 20. AUTOPSY? | | | | | | |
| Sept 1968 | | Lung biopsy for carcinoma | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL
SIGNATURE | | John Kehoe, M.D., Riverdale | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-16-69 |
| EXAMINER'S
NAME (Type) | | John Kehoe, M.D., Riverdale | | ADDRESS (Street, city, town, or county) | | Cheverly, Md. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5-19-1969 | | Resthaven Memorial Gardens | | Frederick Co. Maryland | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Robert E. Dailey & Son | | Frederick, Maryland | | MAY 22 1969 | | J. Charles Jones | | | | |

03363

FOR STATE
DEPT.

MINISTRE DES AFFAIRES ETRANGERES
DEPARTEMENT DES AFFAIRES ETRANGERES

117

TO THE SECRETARY OF STATE
WASHINGTON, D. C.
FROM THE MINISTER OF EXTERIOR AFFAIRS
OTTAWA, CANADA
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal communication or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23
15
2

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|---|---|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Betty | | | Jane | | Lowe | Month
May Day
7, Year
69 | | | 3:32 P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | | |
| Female | | White | | 6-29-27 | | 41 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | U. S. A. | | | | Prince Georges Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of adult life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Riverdale | | | Eugene Leland Memorial Hosp. | | | H. Wife | | Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | | Mont. | | Silver Spring | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 4412 Rigley Rd., | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | |
| John | | | William | Best | | Ethel May Lowe | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| Yes, no, or unknown
no | | | | | husband/Medical Record | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE CEREBRAL HEMORRHAGE</u>
<u>4309</u>
DUE TO, OR AS A CONSEQUENCE OF (b)
(SPONTANEOUS, CIRCLE OF WILLIS)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 DAYS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> , 19 <u>69</u> , to <u>5-7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
<u>DR. KEHOE NOTIFIED</u> | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>C. J. Houmann</u> | | | | | | | | | <u>7 MAY 69</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| C. J. Houmann, M. D. | | | | | 4400 Queensbury Road, Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | May 12, 1969 | | Parklawn | | Rockville Mont. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Francis H. Barber | | | | | Laytonsville, Md. | | MAY 12 1969 | | <u>Francis H. Barber</u> | |

07380

CERTIFICATE OF DEATH

202

Home

Label May Love

William Bent

no

Hockville Mont. Md.

Parkman

May 15, 1909

Burial

Francis B. Barber, Laytonville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
45M - 1-1-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|---|---|--|----------------------------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 07369 | | | | | | | | | | |
| 07363 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Josephine Lyles | | | 5 Month 23 Day 69 Year | | | 10 30 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| F | | N | | 8-31-1884 | | 84 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Washington DC | | USA | | | | Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Clinton | | | Pine View Gardens | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| D.C. | | | | | Washington | | | | 1150-12th St. Apt 614 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| John McCarpen | | | Margaret Carter | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | | 579664377 | | Edythe Brent 1905 Lincoln Rd., N.E. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio arrest | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Collapse | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Melanotic Carcinoma | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| Carcinoma of Breast | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/23, 1969, to 5/23, 1969, that (I) (we) last saw the deceased alive on 5/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Alfred R. Capin, M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) ALFRED R. CAPIN, M.D. | | | | | 22e. ADDRESS CLINTON, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-29-69 | | Harmony Memorial Park | | | Landover, Maryland | | | |
| 24. FUNERAL DIRECTOR Rollins F.H. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | 4339 Hunt Pl. N.E. | | MAY 29 1969 | | Charles Judge | | |

07383

TO: SAC, NEW YORK (100-100000) FROM: SAC, NEW YORK (100-100000)

RE: NEW YORK (100-100000) (NY 100-100000) (NY 100-100000)

MAY 20 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2049

10

1

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|--|---|---|--|-----------------------------------|--|--|
| <div style="display: flex; justify-content: space-between;"> 07370 CERTIFICATE OF DEATH 07364 </div> | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| Odessa S. Maitre | | | | | Month May Day 30, Year 1969 | | 5:15P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Female | | White | | 8/29/95 | | 73 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Iowa | | U. S. A. | | | | Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George's Gen. Hosp. | | | Housewife | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Prince George's | | Bowie | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12310 Rockledge Dr. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| William Spaur | | | Tibitha Wharton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | | 482 16 8822 | | Ward J. Maitre Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Sepsis</u> | | | | | | | | | 10 days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | 10 days | |
| (b) <u>Paratyphoid</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) <u>Symphocytic leukemia</u> | | | | | | | | | 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Nov 15, 1968</u> , to <u>May 30, 1969</u> , that (I) (the hospital) saw the deceased alive on <u>May 30, 1969</u> , and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) <u>(did)</u> (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>Leonard P. Appel, M.D.</u> | | | | | | | May 31, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| Leonard P. Appel, M.D. | | | | | 3231 Superior Lane, Bowie, Md. 20715 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 6/4/69 | | Memory Gardens | | Concord California | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Francis Gasch's Sons | | | | Hyattsville, Maryland | | JUN 4 1969 | | <u>Charles Judge</u> | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

ITEMS 18-22a Film 414 MARYLAND STATE DEPARTMENT OF HEALTH
7-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07365

| | | | | | | | | | | | |
|---|---------|--|--------------------------|---|---|--|--|--|----------|--|------|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | | | | 2b. HOUR | |
| Vincent Paul Mandley | | | | | | OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5-2-69 19 4:00am | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR | | |
| Male | White | 8-26-1905 | | 63 YRS. | | | 5 2 69 19 6:06am M | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington D.C. | | U.S.A. | | Prince George's Md | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | Prince George Hospital | | Painter | | Self | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | Prince George's | | Hillside | | YES | | 830 53rd. Avenue | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Unknown | | | | | | Agnes | | | | | Dean |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | | |
| no | | | 578 26 3340 | | | Vincent R. Mandley Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
3039
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Aspiration of gastric contents
DUE TO, OR AS A CONSEQUENCE OF Vomiting -
(c) Associated with acute alcoholism | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe M.D. Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5-2-69 | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 5/5/69 | | Cedar Hill | | Suitland P.G. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR
MAY 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Mr. Robert D. Fowler -

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 07372 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | CERTIFICATE OF DEATH | | 07366 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Beniah Elmer Manuel | | | 2a. DATE OF DEATH
Month Day Year
May 3, 1969 | | | 2b. HOUR
14 M | |
| 3. SEX
Male | | 4. RACE
Caucasion | | 5. DATE OF BIRTH
Oct. 12, 1881 | | 6. AGE (In years last birthday)
87 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Canada | | 7b. CITIZEN OF WHAT COUNTRY?
Canada | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | |
| 10. CITY OR TOWN OF DEATH
Adelphi | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Hillhaven Nurs Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Clergy | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Va. | | 13b. COUNTY
Shenandoah | | 13c. CITY OR TOWN
New Market | | 13d. INSIDE CITY ADDRESS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
Jacob Manuel | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Phoebe Moore | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
223-50-5442 | | 17. INFORMANT
Nursing Home Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 401X Probable Pul. Embolus
DUE TO, OR AS A CONSEQUENCE OF (b) Gen. arteriosclerosis - Marked Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) Sec. Cerebrum | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5/3/69 | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/21, 1969, to 5/3, 1969, that (I) (we) last saw the deceased alive on 4/21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Howard T. Morse | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/3/69 | |
| 22d. PHYSICIAN'S NAME (Type)
Howard T. Morse M.D. | | | | 22e. ADDRESS
7030 Carroll Ave Takoma Park Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 6, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Cem. | | 23d. LOCATION (City or Town) (County) (State)
Adelphi Pr. Geo. Md | |
| 24. FUNERAL DIRECTOR
Arthur Waller | | | | ADDRESS
254 Carroll NW. DC | | 25a. REC'D BY REGISTRAR
DATE MAY 6 1969 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

George Washington

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

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Washington, D. C.

Washington, D. C.

Washington, D. C.

Washington, D. C.

1619
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07373

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07367

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|---|--|--|------------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
HAROLD E. MARTIN | | | 2a. DATE OF DEATH
Month Day Year
MAY 20 1969 | | | 2b. HOUR
Min
1:25 PM | | | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Unknown | | 6. AGE (In years last birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Unknown | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Clinton, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Pine View Gardens | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Medicine | | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
P.G. | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
3733 Wells Ave | | | | | | |
| 14. FATHER'S NAME First Middle Last
UNK | | | 15. MOTHER'S MAIDEN NAME First Middle Last
UNK | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
579-05-9563 | | | | | |
| 17. INFORMANT
Chas E. Hibbard | | | Address
3733 Wells Ave
MT Rainier Md | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory Collapse
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of Lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/24/69 to 5/20/69 , that (I) (we) last saw the deceased alive on 5/20/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | 22b. SIGNATURE
Alfred R. Lapin | | | 22c. DATE SIGNED
5/20/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
ALFRED R. LAPIN, MD | | | 22e. ADDRESS
CLINTON, MD | | | 22f. ADDRESS
CLINTON, MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | | 23b. DATE
5/20/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
St Lincolns Crematory | | | 23d. LOCATION (City or Town) (County) (State)
Calver Manor Md | | | | | |
| 24. FUNERAL DIRECTOR
NALLEYS Funeral Home | | | ADDRESS
3200 R. 2 Ave | | | 25a. REC'D BY REGISTRAR
MAY 22 1969 | | | 25b. REGISTRAR'S SIGNATURE
William H. Judge | | | | | |

013358

RECEIVED
MAY 2 1969

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

MAY 2 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 07374 | | CERTIFICATE OF DEATH | | | | 07368 | | | |
| 1. DECEASED-NAME
(Type or print) <i>Richard</i> | | | First Middle Last <i>MARTIN</i> | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>20</i> Year <i>69</i> | | | 2b. HOUR
<i>1:55</i> A M |
| 3. SEX
<i>M</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>8/6/1906</i> | | 6. AGE (In years last birthday)
<i>62</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Michigan</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Prince George</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Clinton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Funeral Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Watch maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>Charles</i> | | 13c. CITY OR TOWN
<i>LaPlata</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Line Street</i> | |
| 14. FATHER'S NAME
First Middle Last
<i>Unknown</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Marquerite Weaver</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) <i>Unknown</i> | | 16b. SOCIAL SECURITY NO.
<i>Unknown</i> | | 17. INFORMANT
<i>Lillian T. Martin - LaPlata, Md</i> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>
<i>4124</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cerebral Vascular Accident</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arteriosclerotic Cardiovascular Disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/18/59</i> , to <i>5/20/69</i> , that (I) (we) last saw the deceased alive on <i>5/20/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Alfred R. Lapidus</i> | | | | DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS.
MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>ALFRED R. LAPIDUS</i> | | | | 22e. ADDRESS
<i>CLINTON, MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Funeral Home</i> | | 23b. DATE
<i>May 22, 69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Sunset Memorial Park</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>LaPlata, Prince George's Co, MD</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Richard Thompson</i> | | | | ADDRESS
<i>Franklinburg Vt</i> | | REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |
| MAY 22 1969 | | | | | | | | | |

07574

STATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

2-1-79 000 00 00

0092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Continued on page 4

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|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|
| 07375 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07369 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Martha H. May | | | | | | | | | | 2a. DATE OF DEATH May Month 22 Day 1969 Year | | | | | | | | | | 2b. HOUR 5:30 AM | | | | | | | | | |
| 3. SEX Female | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH 25 July 1883 | | | | | 6. AGE (In years) 85 (In months) 1 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) Ohio | | | | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Pr. Geo. Prince George's Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3514 Longfellow St. | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | 13b. COUNTY Pr. Geo. | | | | | 13c. CITY OR TOWN Hyattsville | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 3514 Longfellow Street | | | | | | | | | |
| 14. FATHER'S NAME First Frederick Middle H. Last Schumacher | | | | | 15. MOTHER'S MAIDEN NAME First Elizabeth Middle Benecke Last | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16b. SOCIAL SECURITY NO. None | | | | | 17. INFORMANT Joan E. May | | | | | Address Same as # B | | | | | 17b. Relationship Daughter | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VIRAL GASTRO-ENTERITIS
009.2
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 Yrs. | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
GENERALIZED ARTERIOSCLEROSIS & OLD CEREBRO-VASCULAR ACCIDENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-20 19 68 , to May 22 19 69 , that (I) (we) last saw the deceased alive on 12-20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Ronald S. Fleischer | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED 5-22-69 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER, M.D. | | | | | | | | | | 22e. ADDRESS 744 RIGGS RD HYATTSVILLE, MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, ETC. Burial | | | | | 23b. DATE 5/24/69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Ceme. | | | | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pr. Geo. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons | | | | | | | | | | ADDRESS Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR MAY 23 1969 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Jones | | | | | | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07376

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07370

| | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|---|--|---------|--|-------|--|-----------|--|-----------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | McPHERSON
McPherson | | 2a. DATE KNOWN OF DEATH | | Month | | Day | | Year | | 2b. HOUR | |
| Stanley | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> | | 5 | | 30 | | 19 69 | | 8:30 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | Month | | Day | | Year | | 2d. HOUR | |
| M | W | 2 Aug., 1952 | | 16 YRS | | MONTHS | | DAYS | | 5 | | 30 | | 19 69 | | 9:40 A.M. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | | | | |
| No. Car. | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Prince George | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street-address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Cheverly | | Prince George Hosp | | Student | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | | | | | | | | | | | | | |
| District of Columbia | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6400 E. St., N.E., | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | | | | | |
| Joseph McPherson | | | | | | | | Elva Johnson | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| | | 577-74-0711 | | Mrs. Elva McPherson; Same as #13 above | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Laceration of brain | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 816.0 | | DUE TO, OR AS A CONSEQUENCE OF | | Trauma auto Accident | | Minutes | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | Dr. ver of car which ran off rd at 84th and Sheriff Rd. P.G. Co | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | | | | | | | |
| Street | | Sheriff Rd | | P.G. | | Md. | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: | | Natural causes <input type="checkbox"/> | | Accident <input checked="" type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe, M.D., Riverdale | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | | 5-31-69 | | | | | | | |
| EXAMINER'S NAME (Type) | | John Kehoe, M.D., Riverdale | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | | | | | |
| Burial | | 6/4/69 | | Harmony Mem. Park | | Highland Park, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Robert G. McGuire | | 1820 9th St., N.W. | | JUN 5 1969 | | K. Charles Judge | | | | | | | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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07377

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07371

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|--|--|---------|-------------------|------------------------------|--|---|--|---|----------------|-------------------------------|--|--|--|-----------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | | Month Day Year | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Charles | | | Melvin | | | Meador III | | | 5-1-69 | | | 1912:30am | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | White | | 11-12-1951 | | 17 YRS. | | | | | | 5 1 69 | | 1912:41am | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Washington D C | | | | U S A | | | | | | | | Prince George's Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cheverly | | | | | | Prince George Hospital | | | | | | Painting co | | | | | | Painting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | | | 13b. COUNTY | | | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | |
| Maryland | | | | | | | | | | | | Prince George's | | | | | | | | | | | | Hyattsville | | | | | | | | | | | | | | | | | | | | | | | | 7007 Farragut Street | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | First Middle Last | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Charles M Meador jr | | | | | | | | | | | | Margaret J Powers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| no | | | | | | 212 54 6766 | | | | | | Charles M Meador Jr | | | | | | Hyattsville Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Laceration of brain</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Skull fracture</u>
(b) <u>Trauma - auto accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | | | | | | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
12:29am 5-1- 1969 | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)
Driver of car involved in collision | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE
AT WORK | | | | | | | | | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
7400 block Annapolis Rd. Glen Ridge, Prince George Co., Md. | | | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. DATE SIGNED
5-2-69 | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | | | | | | | | | | 23b. DATE
May 3, 1969 | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons | | | | | | | | | | | | ADDRESS
Hyattsville, Md. | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 5 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07378 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 07372 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) GEORGE HAMILTON MILES | | | | | 2a. DATE OF DEATH
Month 5 Day 6 Year 1969 | | 2b. HOUR
5 A. M. | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUG. 4 - 1925 | | 6. AGE (In years last birthday)
43 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGE Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince Georges Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
PRINTING | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
PRINCE | | 13c. CITY OR TOWN
CLINTON | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6108 WOODLAND LA. | |
| 14. FATHER'S NAME First Middle Last
GEORGE THOMAS MILES | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
GLADYS B. BARBER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO.
578-28-773 | | 17. INFORMANT
ROSINA E. MILES (ITEM 13) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4100
DUE TO, OR AS A CONSEQUENCE OF HYPERTENSIVE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ATHEROSCLEROTIC CV DISEASE > 1 Yr.
DUE TO, OR AS A CONSEQUENCE OF
(c) RHEUMATIC HD: AORTIC INSUFFIC. X | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
OVERWORK, OVERUSE OF "CONTRA" AS SEDATIVE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY , 19 68 , to DEATH , 19 69 , that (I) (we) last saw the deceased alive on MAY 2 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert W. Merkle M.D. | | | | | 22c. DATE SIGNED
5 MAY 69 | | 22d. PHYSICIAN'S NAME (Type)
Robert W. Merkle, M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/9/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | | 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home
4308 Suitland Rd., S.E., Suitland, Md. 20023 | |
| 25a. REC'D BY REGISTRAR
MAY 8 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
William J. Jones | | | | |

27650

13

07379

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07373

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|-------------------------|---|--|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or Print)
LESTER W MOLER | | | 20. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> May 8 1969 | | | 2b. HOUR
8:50 P M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
25 Apr 1923 | 6. AGE (In years last birthday)
46 YRS. | IF UNDER 1 YEAR
MONTHS
0 | DAYS
0 | IF UNDER 24 HRS
HOURS
0 | MIN.
0 | 2c. DATE PRONOUNCED DEAD
Month May Day 8 Year 1969 |
| 7a. BIRTHPLACE (State or foreign country)
S. Dakota | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's | | |
| 10. CITY OR TOWN OF DEATH
Suitland, Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired USN Chief | | | 12b. KIND OF BUSINESS OR INDUSTRY
Admin Asst |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Suitland | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
4815 Romain Court | |
| 14. FATHER'S NAME
First EDWARD Middle MOLER Last MOLER | | | 15. MOTHER'S MAIDEN NAME
First HAZEL Middle DEAN Last DEAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Mrs Kathleen P. Moler Same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration of gastric contents
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 911X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Min. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
8:50 P.M. 5 8 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Vomited and aspirated | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No.
Same as #13 | | City or Town
County
State | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
John Kehoe | | EXAMINER'S NAME (Type)
John Kehoe, M.D., Riverdale | | M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-8-69. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-12-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Olive Branch Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Portsmouth Norfolk Va. | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home
4308 Suitland Road Suitland Maryland | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 14 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

01370

MEDICAL EXAMINATION REPORT ON DEATH

Name: J. P. ... Date: 22 Apr 1951 Age: 45 Sex: M

Address: ... City: ... State: ...

Occupation: ...

Medical History: ...

Family History: ...

Physical Examination: ...

Pathological Findings: ...

Diagnosis: ...

Comments: ...

Signature: ...

Witness: ...

Death Certificate: ...

Coroner's Office: ...

Medical Examiner: ...

Pathologist: ...

Forensic Scientist: ...

Medical Record: ...

Death Record: ...

Final Report: ...

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|---|---|---|--|---|--|
| <div>07380</div> <div>07374</div> | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Florence Elizabeth Morgan | | | | | | ESTI-
MATED 5-28-69 | | | 19 12:02pm |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | |
| Female | White | 4-8-1910 | 59 YRS. | | | | | Month 5 Day 28 Year 69 19 12:45pm | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George Hospital | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Prince George's | | | Forestville | | 7818 Marlboro Pike | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Clarence Zeigler | | | Mary Shane | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| | | | | | Charles E. Morgan 7818 Marlboro Pike | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>
<u>1829</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of uterus</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
over 2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| John Kehoe | | | John Kehoe M.D. Riverdale, Md. | | | | | 5-29-69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-31-1969 | | Frederick Memorial Cem | | Frederick Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert E. Wilhelm Funeral Home
4308 Suitland Road Suitland Maryland | | | | | | DATE JUN 4 1969 | | R. E. Wilhelm | |

03830

8300 Building Road Building Building
George E. Wilkins Building House
3-31-1999 Frederick Memorial Cam Frederick Maryland

Charles E. Brown 7818 Maryland 5196
Mary
Charles

household

building

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

1

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 07381 | | | | | 07375 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | | | |
| First | | Middle | | Last | | Month | | Day | | | |
| George | | L. | | Mortimer | | May | | 15 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | | |
| Male | | White | | 02-21-89 2/21/92 | | 80 77 YRS. | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington, D.C. | | USA | | | | Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince Georges Gen. Hosp. | | | Plumber | | | Construction | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | | Prince George's | | | Suitland | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5500 Shadyside | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First | | Middle | | Last | | First | | Middle | | Last | |
| Joseph H. | | Mortimer | | | | Jane | | Alice | | Herbert | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| yes | | | | 1910-1911 | | Miss Mary Pierce, Step Daughter 5500 Shadyside Avenue, Suitland, Md., 20023 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) — Arteriosclerotic heart disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) Cardiomegaly | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) this hospital attended the deceased from May 7, 1969, to May 15, 1969, that (X) (we) last saw the deceased alive on May 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | 22c. DATE SIGNED | | |
| Luis Bentolia | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | 22e. ADDRESS | | |
| Luis Bentolia, M.D. | | | | | | | | | Prince George's Gen. Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 5/19/69 | | Cedar Hill Cemetery | | | Suitland, Maryland, 20023 | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert E. Wilhelm Funeral Home 4308 Suitland Road, S.E., Suitland, Md., 20023 | | | | | | MAY 19 1969 | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) <i>Myette</i> | | | First <i>Myette</i> Middle <i>De</i> Last <i>Maxley</i> | | | 2a. DATE OF DEATH
Month <i>MAY</i> Day <i>14</i> Year <i>1969</i> | | | 2b. HOUR
<i>9:00 A.M.</i> |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
<i>1/6/1883</i> | | 6. AGE (In years last birthday)
<i>86</i> | | 7. IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Prince George</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Crofton Md</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Magnolia Speders Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i></i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i></i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <i>Md</i> COUNTY <i>Pr</i> | | 13b. CITY OR TOWN
<i>Woods Dr</i> | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1018 Maryland Ave N.E.</i> | | | |
| 14. FATHER'S NAME
First <i>Elmer</i> Middle <i>Moore</i> Last <i>Moore</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Catherine</i> Middle <i>Phoebe</i> Last <i>Phoebe</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i></i> | | 17. INFORMANT
<i>Mary Eyn 2124 Pitt St</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>4339</i> IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 3 days
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Branchial Pneumonia</i> 3 days
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i></i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-24</i> , 19 <i>67</i> , to <i>5-14</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-14-69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Dr L. Levitsky</i> | | | | 22e. ADDRESS
<i>3408 R. Lane Mt Rainier Md</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>5-19-1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Arlington Hall</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Farmington Arlington Va</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Notting 131-11th St S-Wash DC</i> | | | | 25. REC'D BY REGISTRAR
<i>MAY 19 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

02885

CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT THE FOLLOWING PERSON HAS DECEASED

| | |
|------------------------|--|
| Name of Deceased | |
| Age | |
| Sex | |
| Race | |
| Date of Death | |
| Place of Death | |
| Cause of Death | |
| Signature of Physician | |
| Signature of Registrar | |
| Date of Registration | |
| Place of Registration | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. My delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07383 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07377

| | | | | | | | | | | | |
|--|---------|------------------|---|---|--|---|--|--|---|--|----------|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5-4-69 196:16pm | | | 2b. HOUR | | |
| James Richard Oates | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR |
| Male | White | 4-20-1950 | 19 YRS. | | | | | 5 Day 4 69 198:25pm M | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Washington, D.C. | | | USA | | | | | | Prince George's Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Cheverly | | | Prince George Hospital | | | Instrument Man | | | PG County | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Maryland | | | Prince George's | | | Forestville | | | 6001 Surry Square Lane | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | |
| George E. Oates | | | Mary E. Tyrell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
ADDRESS | | | | | |
| no | | | | | | Frank W. Smith, General Delivery
Tall Timbers, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gun shot wound of neck</u>
9229 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
6:15pm 5-4- 19 69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Shot by accidental discharge of gun | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
home | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
same as #13 | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE <u>John Kehoe</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
5-5-69 | | | |
| EXAMINER'S
NAME (Type) John Kehoe MD | | | | Riverdale, Md. | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 5/7/69 | | | Epiphany Church Cemetery | | | Forrestville, Maryland | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home
4308 Suitland Rd., S.E., Suitland, Md., 20023 | | | | | | 25a. REC'D BY REGISTRAR
MAY 8 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

07583

570

RECEIVED 10/10/50

11/11/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 07384 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07378 | |
| Item 13 Film 413 6/16/69 kk | | | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Sarah nmi Oken | | | 5 Month 31 Day 69 | | | 10:30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| female | | white | | 1/17/96 | | 13 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Russia | | US | | | | Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Riverdale | | | Leland Memorial | | | homemaker | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | | 13c. STREET AND NUMBER | |
| Maryland D.C. Montgomery | | | Washington Silver Spring | | | 5024 Ringle St. Home | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 16. KIND OF BUSINESS OR INDUSTRY | |
| Mayer Meyerowitz | | | not known | | | Arthea Woodland Nursing | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | |
| No | | | 577-20-1876 | | | Gilbert Oken 2400 V.A. Ave N.W. D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis | | | | | | Sudden | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis | | | | | | Undetermined | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr 9, 1969, to May 31, 1969, that (I) (we) lost the deceased alive on May 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE L.W. Martin | | | | DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED May 31, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) L.W. Martin M.D. | | | | 22e. ADDRESS Riverdale, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE June 1, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Memorial | | 23d. LOCATION (City or Town) (County) (State) Hyattsville, Md | |
| 24. FUNERAL DIRECTOR C.D. Goldberg | | | | 25a. REC'D BY REGISTRAR JUN 3 1969 | | 25b. REGISTRAR'S SIGNATURE | |

2250

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

01-10-2000 10:20

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|---|---|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| Items #1 & 13 taken from birth certificate | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
Twin II Ricky Lee | | | 2a. DATE OF DEATH
Month Day Year
May 10 1969 | | | 2b. HOUR
1629 PM | | | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
May 10, 1969 | | 6. AGE (in years last birthday)
YRS. MONTHS DAYS | | IF UNDER 1 YEAR
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH
Camp Springs | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Malcolm Grow USAF Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
District Hts | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7904 Foster Street | |
| 14. FATHER'S NAME
First Middle Last
ROBERT LESLIE OLIVER | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
LINDA JEAN BUZZARD | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
FATHER | | Address
7904 Foster St, District Heights | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hyaline Membrane disease.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>5 hrs.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 May, 1969</u> , to <u>10 May, 1969</u> , that (I) (we) last saw the deceased alive on <u>10 May, 1969</u> , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>John B. Watkins MD</u> | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10 May 69.</u> | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN B. WATKINS | | | | 22e. ADDRESS
Malcolm Grow USAF Hospital Andrews AFBMD | | | | | |
| 23a. BURIAL CREMATION
REMOVAL (Specify) | | 23b. DATE
<u>6/13/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
PUBLIC CREMATION | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
<u>Carl F. Campbell</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 12 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>John Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07386

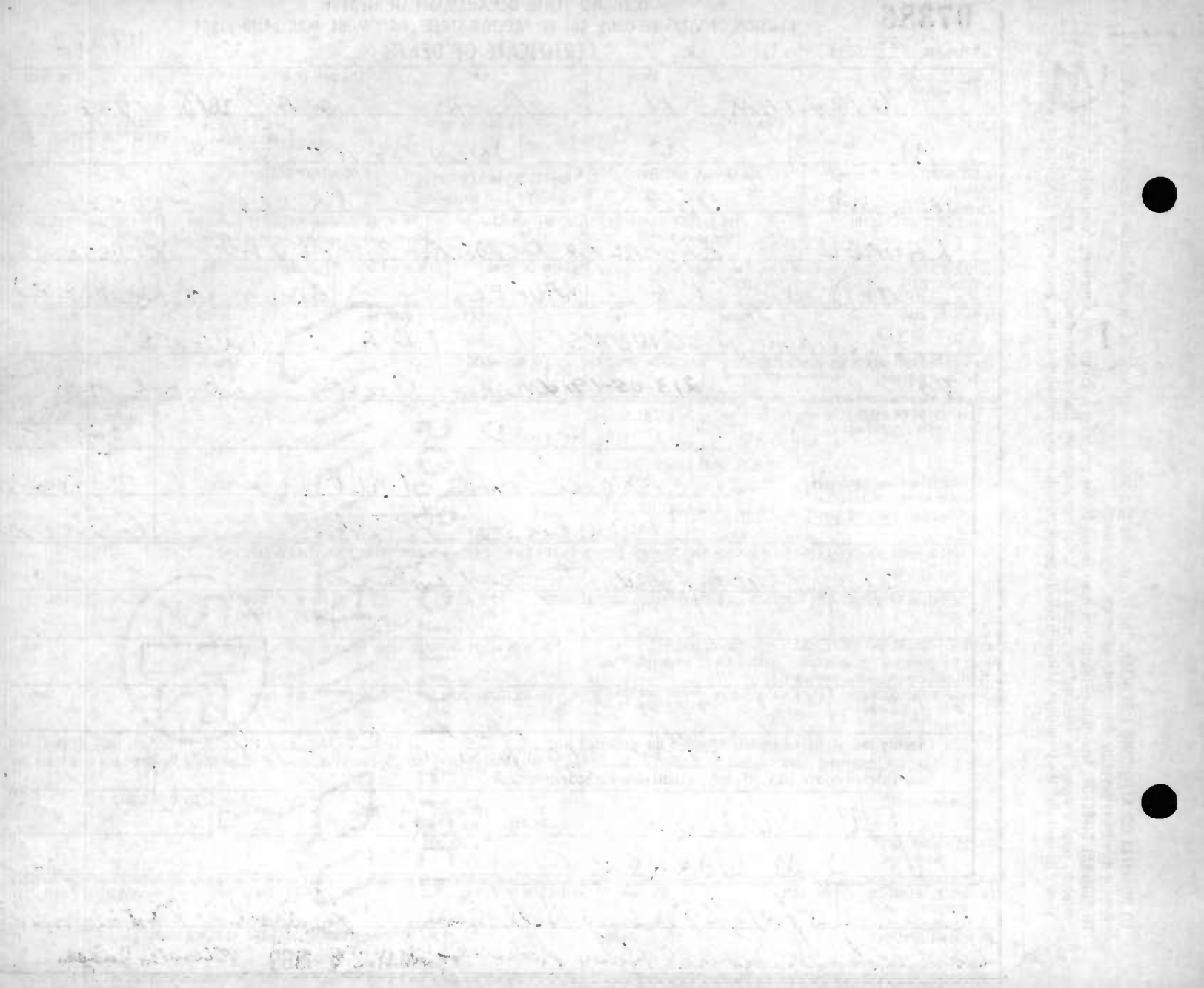
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07379

Item 2a Film 413 6/16/69 kk

CERTIFICATE OF DEATH

| | | | | | |
|---|--------------|---|---|---|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
WILLIAM A OWENS | | | 2a. DATE OF DEATH
Month Day Year
MAY 18 1969 | | 2b. HOUR
M |
| 3. SEX
M | 4. RACE
W | | 5. DATE OF BIRTH
JULY 14 1895 | | 6. AGE (in years
last birthday)
73 YRS. |
| 7a. BIRTHPLACE (State or foreign
country)
LAUREL MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
PRINCE GEORGE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
LAUREL | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
BROOKLYN BRIDGE RD | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
CONSTRUCTOR | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
MD | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
LAUREL | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
BROOKLYN BRIDGE RD | | | |
| 14. FATHER'S NAME
First Middle Last
WILLIAM N. OWENS | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
IDA E. OWENS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
NO | | 16b. SOCIAL SECURITY NO.
213-05-1914 | | 17. INFORMANT
Address
MARIE OWENS LAUREL, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C-S-E-V-D
157.9
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma prostate
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma bladder
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
34 hr
2 yr
6 mo | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
Urinary tract infection | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2, 1969, to 5/16, 1969, that (I) (we) last
saw the deceased alive on 5/17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
J. M. WARREN | | DEGREE
ATTENDING
PHYS. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S
NAME (Type)
J. M. WARREN | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
5/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Inglis Hill Cem. | |
| 23d. LOCATION (City or Town) (County) (State)
Laurel Md. | | | | | |
| 24. FUNERAL DIRECTOR
Canadian Funeral Home Laurel | | 25a. REC'D BY REGISTRAR
DATE MAY 28 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 07387
HERBERT
HERBERT J. PARKER | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
HERBERT J. PARKER | | | 2a. DATE OF DEATH
Month Day Year
5 29 69 | | | 2b. HOUR
6:19 A M | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
6-3-97 | | 6. AGE (In years last birthday)
71 yrs. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
PENNA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGES Md. | | | |
| 10. CITY OR TOWN OF DEATH
ADELPHI | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NURSING MANOR CARE HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
oil Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
473
ADELPHI | | 13b. COUNTY
Wash., D.C. | | 13c. CITY OR TOWN
4010 - 10th St. N.E. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last
JOHN Parker | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah MILLER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | 16b. SOCIAL SECURITY NO.
225-05-0467A | | 17. INFORMANT
Marie Reilly Parker - above ad- | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Brain Syndrome</u> (Wife) dress 6 months
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral neoplasm</u> 6 months
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral infarction</u> 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Liver Metastases</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July, 1964</u> to <u>May 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Edward J. Pacious M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>5-29-69</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Edward J. PACIOUS MD</u> | | 22e. ADDRESS
<u>915-19th ST. N.W. D.C.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>5/31/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Wash., D.C.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Nalley's Funeral Home Inc.</u> | | ADDRESS
<u>Mt. Rainier Maryland</u> | | DATE
<u>JUN 4 1969</u> | | 25b. SIGNATURE
<u>[Signature]</u> | | | |

MEMORANDUM FOR THE RECORD

DATE: 10-3-54

TO: MR. TOLSON

FROM: MR. [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

Very truly yours,

[illegible signature]

[illegible title]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

4123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Andrew | | | J | | | Pemberton | | | Month 5 Day 16 Year 1969 9:30 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| Male | | white | | 13th. July 1876 | | 92 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Na. | | U.S.A. | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George's | | | Foreman | | | Moving |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | P. G. | | Riverdale | | | | 5610 Powhatan Street | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| ? | | | Pemberton | | | Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address |
| No | | | 578-16-9409 | | | Norman Pemberton | | | 2103 Rutan Street Adelphi, Md |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiac + Resp. arrest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| 4123 | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) senility | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Coronary Heart Disease | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| (R) Indirect Inguinal Hernia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/2, 1969, to 5/16, 1969, that (I) (we) last saw the deceased alive on 5/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| Edwin Jensen MD | | 5/12/69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Edwin S. Jensen | | Prince George's Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF BURIAL OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Cremation | | 5/19/69 | | Ft. Lincoln | | Colmar Manor P.G. | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis Gasch's Sons Hyattsville, Md. | | | | MAY 21 1969 | | Charles Judge | | | |

1. *Pinus strobus* L.
 2. *Pinus resinosa* A. Mill.
 3. *Pinus rigida* Mill.
 4. *Pinus taeda* (L.) Mill.
 5. *Pinus strobus* L.
 6. *Pinus resinosa* A. Mill.
 7. *Pinus rigida* Mill.
 8. *Pinus taeda* (L.) Mill.
 9. *Pinus strobus* L.
 10. *Pinus resinosa* A. Mill.
 11. *Pinus rigida* Mill.
 12. *Pinus taeda* (L.) Mill.

13. *Pinus strobus* L.
 14. *Pinus resinosa* A. Mill.
 15. *Pinus rigida* Mill.
 16. *Pinus taeda* (L.) Mill.
 17. *Pinus strobus* L.
 18. *Pinus resinosa* A. Mill.
 19. *Pinus rigida* Mill.
 20. *Pinus taeda* (L.) Mill.
 21. *Pinus strobus* L.
 22. *Pinus resinosa* A. Mill.
 23. *Pinus rigida* Mill.
 24. *Pinus taeda* (L.) Mill.
 25. *Pinus strobus* L.
 26. *Pinus resinosa* A. Mill.
 27. *Pinus rigida* Mill.
 28. *Pinus taeda* (L.) Mill.
 29. *Pinus strobus* L.
 30. *Pinus resinosa* A. Mill.
 31. *Pinus rigida* Mill.
 32. *Pinus taeda* (L.) Mill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| Katherine Perrier | | | | | | 5 1 69 | | 1:45A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Female | | White | | 11-24-96 | | 72 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Austria | | U.S.A. | | | | Prince George Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Riverdale | | | Leland Memorial Hospital | | | HOUSEWIFE | | OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Prince George | | New Carrollton | | | | 8606 Fremont St. | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| Karol Horak | | | unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | | | | | |
| unknown | | | unknown | | Marguerite Roosen, 8606 Fremont Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Intractable CHF</u>
4124 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASERD, severe Kyph-scoliosis, polycythemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>69</u> , to <u>4/30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Verner Albertsen, M.D.</u> | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5/1/69</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Verner Albertsen</u> | | | | | 22e. ADDRESS
<u>4408 Queensbury Rd., Riverdale, Maryland</u> | | | | | |
| 23a. BURIAL CEMETERY OR CREMATORY
<u>Calvary Cemetery</u> | | 23b. DATE
<u>May 3, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Calvary Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Patterson, New Jersey</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | | | | 25a. REC'D BY REGISTRAR
DATE
<u>MAY 5 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Warner E. Pumphrey</u> | | | |

073224

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

Memorandum for the Director

Subject: [Illegible]

Reference: [Illegible]

Enclosure: [Illegible]

Date: [Illegible]

By: [Illegible]

For the Director: [Illegible]

Special Agent in Charge

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH Items 18-22a Film 413 | | | | | | | | | |
|---|---------|------------------------------|--|--|--------------------------------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 6-9-69 ams | | | | | | | | | |
| Item#2a, Film GL13 6/7/69 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> May 17 1969 | | | 2b. HOUR a 3:00M |
| John R. Perry Jr. | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year | | | 2d. HOUR a 7:48M |
| Male | White | 7-7-26 | 42 YRS. | | | 5-17-69 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Ohio | | U.S.A. | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Adelphi | | | Prince George's | | | Truck Driver | | | Nurse |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| Md. | | | Prince Geo. | | | Adelphi | | | 9400 Riggs Rd. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| John R. Perry, Sr. | | | Ida Mcglone | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| Yes | | | W.W.11 | | | 275 24 9378 Eugene Perry Star Rt. Staut, Ohio | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon monoxide intoxication | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 5-17-19 69 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.) | | | |
| | | | AM | | | Connected rubber hose from exhaust pipe to cab of truck | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | 9400 Block Riggs Rd. | | | Adelphi P.G. Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 5-17-69 | | | |
| Victor A. Fazekas, M.D. | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | May 21, 1969 | | Bethel Cemetery | | Olive Hill Carter Kentucky | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons 4739 Balto. Ave.. Hyattsville, Md. | | | | MAY 21 1969 | | Charles Judge | | | |

07330



... 1900 ...
... 1900 ...
... 1900 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 07391 | | | | | | | | | |
| 07384 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| James | | | G. Phillips | | | 5-4-69 Month Day Year | | | 10:37 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | May 10, 1899 | | 69 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | M.D. | |
| N. Y. | | U.S.A. | | | | Prince George | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George Gen. Hospital | | | Ret. Navy Yard | | | Government |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | | | |
| Maryland | | Prince George | | Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3510 55th Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| George | | | Phillips | | | Sophia Zimmerman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| Yes | | | WW I & WW II | | | Lillian Phillip | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. DEATH WAS CAUSED BY: | | | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4124 | | | IMMEDIATE CAUSE (a) | | | 15 min | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | CARDIAC ARREST | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | (b) | | | 3 years | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| | | | (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| M/A | | M/A | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | |
| | | | | Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1968, to 5/4/1969, that (I) (we) last saw the deceased alive on April 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| Dennis J. Hand MD | | 5/4/69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| DENNIS J. HAND MD | | 4600 Connecticut Ave NW | | Washington DC | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/7/69 | | Baltimore National | | Baltimore Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis Gasch's Sons Hyattsville, Md. | | | | DATE | | Charles Judge | | | |

10270

1551

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | | | |
|---|-----------------------------|--|---|---|--|---|--|--------|-----|
| 1. DECEASED-NAME
(Type or print) | | First
MARY | Middle
E | Last
REDDINGTON | 2a. DATE OF DEATH
MAY Month 12 Day 69 Year | | 2b. HOUR
5:50 | a
M | |
| 3. SEX
Female | 4. RACE
Caucasian | | 5. DATE OF BIRTH
6 April 1915 | | 6. AGE (In years last 54 day) YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGES | | | Md. |
| 10. CITY OR TOWN OF DEATH
ANDREWS AFB | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last year)
MALCOLM GROW USAF HOSP | | 12a. USUAL OCCUPATION (Kind of work done during last year, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to this institution)
VIRGINIA | | 13b. CITY OR TOWN
PRINCE WILLIAMS | | 13c. INSIDE CITY LIMITS?
NO | | 13e. STREET AND NUMBER
RT 1 BOX 250 | | | |
| 14. FATHER'S NAME
JOHN | | First
FRANKLIN | Middle
GRAHAM | 15. MOTHER'S MAIDEN NAME
CORA | | First
LEE | Middle
PAYNE | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO | | 16b. SOCIAL SECURITY NO.
579-07-9733 | | 17. INFORMANT (HUSBAND)
FRANCIS J REDDINGTON | | Address
SAME AS ITEM 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory ARREST
1951
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) METASTATIC (CEREBRAL) CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) SQUAMOUS CELL CA OF PERINEUM
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN
WEEKS
MONTHS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 Mar , 19 69 , to 12 MAY , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 May , 19 69 , and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard Flax | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
12 May 69 | | | |
| 22d. PHYSICIAN'S
RICHARD FLAX CAPT USAF MC | | 22e. ADDRESS
MALCOLM GROW USAF HOSP ANDREWS AFB | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
May 15 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Stonewall Memory Gard. | | 23d. LOCATION (City or Town) (County) (State)
Manassas, Virginia. | | | |
| 24. FUNERAL DIRECTOR
Baker Funeral Home | | ADDRESS
Manassas, Va. | | 25a. RECD BY REGISTRAR
MAY 15 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

07392

MARY E. REDDINGTON MAY 11 1962

Female Caucasian April 1911

Virginia U.S.A. BRINCE GLOVER

ANDREWS AFB MARYLAND

VIRGINIA PRINCE WILLIAM GAINESVILLE X RT 1 BOX 250

JOHN FRANKLIN GABRIEL CORA (HUSBAND) PAYNE

NO 17-00-733 FRANCIS J REDDINGTON SAME AS ITEM 12

NO

NO

NO

NO

NO

NO

NO

NO

NO

NO

NO

NO

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07393

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07386

| | | | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|--|--|--------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | | | 2b. HOUR | |
| John | | W. | | Reeve | | | | Month <input type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1969 | | | | 11 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. TIME | |
| M | W | 8 Sept 1951 | | 17 YRS. | | MONTHS | | DAYS | | Month 5 Day 90 Year 1969 | | 12:35 am | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Wash. D.C. | | U S A | | | | Prince George | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Cheverly | | Prince George Hosp | | Student | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Md. | | Prince George | | Forestville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3354 Oak Glen Way | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Clyde S. Reeve | | Catherine F. Gates | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | |
| No | | None | | Clyde S. Reeve, | | 3354-Oak Glen Way Forestville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | Laceration of brain | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | Multiple skull fractures | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | Minutes | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | 11:00pm 5 9 19 69 | | | | Passenger in car which overturned. | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | Street | | | | St. Rt. 4 near St. Rt. 223 P.G. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | John Kehoe, M.D., Riverdale | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | 5-10-69 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Burial | | | | 5/13/69 | | | | Resurrection Cemetery | | | | | |
| | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| | | | | | | | | Clinton, Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert E. Wilhelm Funeral Home | | | | DATE MAY 14 1969 | | | | Charles Judge | | | | | |
| 4308-Suitland, Rd., Suitland, Md. | | | | | | | | | | | | | |

07333

FOR MAIL
IN 4/10/57



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a series of lines of communication or a report.]

Enclosure

1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|
| 07394 | | | | | 07387 | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
MARY (MAY) ELIZABETH RICE | | | | | 2a. DATE OF DEATH Month Day Year
MAY 17 1969 | | | 2b. HOUR
M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
FEB. 21, 1899 | | 6. AGE (In years lost birthday)
70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGE Md. | | | |
| 10. CITY OR TOWN OF DEATH
LAUREL | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
702 5TH STREET | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
PR-GEORGE | | 13c. CITY OR TOWN
LAUREL | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
702 5TH STREET | |
| 14. FATHER'S NAME First Middle Last
WILLIAM BROWER | | | 15. MOTHER'S MAIDEN NAME First Middle Last
CELIA NAGLE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
HAROLD RICE ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma pancreas</u>
1579 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma stomach</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs
6 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Generalized Arteriosclerosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1945</u> , 19____, to____, 19____, that (I) (we) last saw the deceased alive on____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. Warden</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/19/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Warden | | 22e. ADDRESS
Laurel Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/19/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Laurel Md | | | |
| 24. FUNERAL DIRECTOR
Conradson Funeral Home, Laurel | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAY 22 1969 | | 25b. REGISTRAR'S SIGNATURE
Richard Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07395 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07388 | |
|--|--|--|---|--|----------|--|------|-----------------------|--|---|-----------------|----------|------------------|----------|--|--|--|--|--|-------|--|
| Item 7 Film 412 5/15/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | | | |
| Leon | | | J. | | Risikoff | | | Month 5 Day 7 Year 69 | | | | 2:55 P M | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | |
| Male | | | White | | | 03-00-94 | | | 75 | | MONTHS DAYS | | HOURS MIN | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | |
| Russia | | | USA | | | | | | Prince George's | | | | Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | |
| Cheverly | | | Prince George's Gen. Hosp. | | | B&B | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS | | | 13e. STREET AND NUMBER | | | | | | | | | | | | |
| MD | | | Prince George's Hyattsville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 2214 Banning Place | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | | | | | | | |
| MENACHEM | | | RISIKOFF | | | ETHEL OCONOWITZ | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | |
| | | | 050-325909 | | | Jacob L. Resnikoff | | | 2214 Banning Pl. Hyattsville, Md. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> | | | | | | | | | | | | | | | | | | | | | |
| 4124 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>ASCVD</u> | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | |
| <u>Diabetes Mellitus Post trauma without remote of possible</u> | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from April 10, 1969, to May 7, 1969, that (1) (we) last saw the deceased alive on May 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | |
| Robert Deitz, M.D. | | | Prince George's Plaza, Hyattsville, MD | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | |
| Robert Deitz, M.D. | | | 5/9/69 | | | Bethesda Cem. | | | Elmont, L.I. N.Y. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Bernard Dangozsky | | | 3501-14th St Wash D.C. | | | MAY 9 1969 | | | Charles Judge | | | | | | | | | | | | |

07335

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5th Ave. New York 17, N.Y.

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
500 5th Ave. New York 17, N.Y.

| Date | Title | Author | Call off | 2 | 1 |
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

07335

MOBILE, ALABAMA, 1964



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07397

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|-------------------|--|--|---|--|--|-------------------|------------------|--|---|--|--|--|----------|--|
| 1. DECEASED-NAME
(Type or Print) | | | First
Martha | | | Middle
A | | | Last
Robinson | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 5-5-69 19 7:18am | | | | 2b. HOUR | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
8-15-1921 | | 6. AGE (In years last birthday)
41 1/2 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD
5 Month 5 Day 69 Year 19 7:45am | | | | 2d. HOUR | |
| 7a. BIRTHPLACE (State or foreign country)
Char. Co. Md. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Prince George's | | | | | |
| 10. CITY OR TOWN OF DEATH
Clinton | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Clinton Medical Center | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | | 13b. CITY OR TOWN
Prince George's Brandywine | | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
Rt3, Box 244B | | | | | |
| 14. FATHER'S NAME
Clarence Lyles | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
Mary Margaret Simms | | | First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | | 17. INFORMANT
Rogers Robinson | | | | ADDRESS
Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral hemothorax</u>
8161
DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - auto accident</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
7:15am 5-5- 19 69 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
a fence. Passenger in car which ran off road and hit | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Baden Road, Prince George's County, Maryland | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (Type) John Kehoe MD | | | | Rivendale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county) | | | | 22b. DATE SIGNED
5-5-69 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE
May 8/69 | | | | 23c. NAME OF CEMETERY OR CREMATORY
St. Thomas Ch. Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Brandywine, P. Ge. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Martell Adams | | | | ADDRESS
Aguasco, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 12 1969 | | | | 25b. REGISTRAR'S SIGNATURE
Richard A. Judge | | | | | |

8337

120-120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 07398 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07391 </div> <div style="display: flex; justify-content: space-between;"> Items 5&6 Film 412 5/19/69 kk CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last
Alida V. Rogers | | | | | | 2a. DATE OF DEATH Month Day Year
May 9 1969 | | | 2b. HOUR P
10:10 M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Dec. 18, 1886 | | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Missouri | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Pro. Geo. | | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Magnolia | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret. Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
P. G. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5801 Queens Chapel Rd. | | |
| 14. FATHER'S NAME First Middle Last
Isadore Vanderbeck | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Adele J. Duquesne Roi | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
497 10 6389 | | | 17. INFORMANT Address
William I. Rogers same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardiac failure</u>
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a).
stating the underlying cause
(b) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>months</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Senile psychosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/1/69</u> to <u>5/9/69</u> , that (I) (we) lost saw the deceased alive on <u>5/8/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Paul A. DeVore M.D.</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-10-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
PAUL A. DEVORE M.D. | | | | | | 22e. ADDRESS
3415 Hamilton St Hyattsville | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/14/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Sun Set Hill Cemetery | | 23d. LOCATION (City or Town)
Harrisburg, | | (County) | | (State)
Illinois | |
| 24. FUNERAL DIRECTOR
F. Gasch's Son | | | | | | ADDRESS
Hyattsville, Maryland | | 25a. REC'D BY REGISTRAR
MAY 13 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07399

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07392

| | | | | | | | | | | | |
|--|--|---|--|---|-------------------|---|---|--|-----------------------------------|---|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| LEVON | | | LOUIS | ROSKO | MAY 2 1969 | | | 2014 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | | CAU | | 19 JUNE 1914 | | 54 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| BARTLETSVILLE, OH | | U.S.A. | | | | PRINCE GEORGE'S | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| ANDREWS AFB | | | MALCOLM GROW USAF HOSP | | | PRINTER | | | MILITARY | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| DELAWARE | | | KENT | | DOVER | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | LOT 31, LAUREL AND TRAILER PK. | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| JOSEPH | | | FELIX | | | ELIZABETH | | | ROSKO | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| YES | | | 65 | | WIFE | | | LOT 31-LAUREL AND TRAILER PK. - DOVER DEL. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the lung</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 min</u>
<u>5 years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
<u>Pulmonary infection</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (this hospital) attended the deceased from <u>22 May</u> , 19 <u>69</u> , to <u>2 May</u> , 19 <u>69</u> , that (he) last saw the deceased alive on <u>27 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Geoffrey A. Graham</u> | | 22c. DATE SIGNED
<u>2 May 69</u> | | 22d. PHYSICIAN'S NAME (Type)
<u>Geoffrey A. Graham, M. D.</u> | | | | | | | |
| 22e. ADDRESS
<u>Malcolm Grow U.S.A.F. Hospital, Camp Springs, Maryland</u> | | 22f. ADDRESS
<u>Malcolm Grow U.S.A.F. Hospital, Camp Springs, Maryland</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/7/69 | | Arlington Nat'l Cem. | | | | Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR
<u>Ritchie Bros. Upper Marlboro, Md.</u> | | | | | | 25a. RECD BY REGISTRAR
<u>MAY 13 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

07833

RECEIVED
FEBRUARY 19 1969

Richard Bros., Upper Marlboro, Md.
2/17/69
Arlington Hall, Va.
Gettysburg, Md.
Hospital, Camp George, England
Lincoln, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|--------|--|---|---|--|----------------------------|--|
| 07400 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07393 | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | |
| Margaret E | | | | | Ross | 5 16 69 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | | |
| Female | | Negro | | 9-19-81 | | 87 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Forestville | | Regent Nursing Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| Dist of Columbia | | | | Washington | | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | |
| William H. Lawson | | | | | Kate C. Carroll | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| NO | | | | Noretha Lamax - 4022 First St SE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> | | | | | | 2 months | | | |
| 402X DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral arteriosclerosis</u> | | | | | | unknown | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiac disease</u> | | | | | | unknown | | | |
| (c) <u>Hypertensive cardiac disease</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/22, 1969, to May 16, 1969, that (I) (we) last saw the deceased alive on May 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | |
| Henry G. Hailey MD | | | | | | May 16 69 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| HENRY G. HALEY MD | | | | | | 4601 Nichols Ave SE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-20-1969 | | Harmony Park | | Sandover, Md. | | | |
| 24. FUNERAL DIRECTOR | | Rollins F.H. | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | 4381 Dean St. NE | | MAY 21 1969 | | Richard Judge | |

00250

009 1 0 222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| 07401 | | | | | CERTIFICATE OF DEATH | | | | | 07394 | | | | |
| 1. DECEASED-NAME (Type or print) Vincent | | | | | First H. Middle Rosson Last | | | | | 2a. DATE OF DEATH
Month May Day 28 Year 1969 | | | | |
| 3. SEX Male | | | | | 4. RACE White | | | | | 5. DATE OF BIRTH
6/8/1902 | | | | |
| 6. AGE (In years last birthday) 66 | | | | | 7. AGE (In years last birthday) 66 | | | | | 8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 9. COUNTY OF DEATH Prince Georges | | | | | 10. CITY OR TOWN OF DEATH Glenn Dale | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unknown - Retired | | | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C. | | | | |
| 13b. COUNTY Washington | | | | | 13c. CITY OR TOWN Washington | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13e. STREET AND NUMBER 1402 M Street, N.W. | | | | | 14. FATHER'S NAME First Marcellas Middle Rosson Last | | | | | 15. MOTHER'S MAIDEN NAME First Alberta Middle Oates Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes 1927 - | | | | | 16b. SOCIAL SECURITY NO. 527-09-6376 | | | | | 17. INFORMANT Decedent | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable myocardial infarction (clinical)
4100 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertensive and arteriosclerotic cardiovascular disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden
years
years | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Pulmonary emphysema; chronic bronchitis. | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/4/ , 1966, to 5/28/ , 1969, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 5/28/ , 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | 22b. SIGNATURE Moe Weiss | | | | |
| 22c. DATE SIGNED 5/28/69 | | | | | 22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | | 22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | | 23b. DATE 6/4/69 | | | | | 23c. NAME OF CEMETERY OR CREMATOR ANATOMICAL BOARD | | | | |
| 23d. LOCATION (City or Town) (County) (State) Washington, D.C. | | | | | 24. FUNERAL DIRECTOR Carl F. Oufelt | | | | | 25a. REC'D BY REGISTRAR JUN 5 1969 | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | |

07407

DEPARTMENT OF STATE

UNITED STATES DEPARTMENT OF STATE
WASHINGTON, D.C.

| | | | | | | |
|------------|---------------------|------------------|---------------|---------------------|----------|------|
| Male | Virginia | U.S.A. | Seattle | Washington | May 1953 | 1953 |
| Glenn Dale | Glenn Dale Hospital | Unknown - listed | Prince George | 1402 N Street, N.E. | 1953 | 1953 |
| Marcellos | Kosovo | Albania | 1953 | 1953 | 1953 | 1953 |
| Yes | 1953 - | 527-08-051 | President | 1953 | 1953 | 1953 |

Probable myocardial infarction (clinical)
arteriosclerotic heart disease
Hypertensive and arteriosclerotic cardiovascular disease
Pulmonary emphysema; chronic bronchitis.

| | | | | | | |
|------------|---------------------|------------------|---------------|---------------------|------|------|
| Glenn Dale | Glenn Dale Hospital | Unknown - listed | Prince George | 1402 N Street, N.E. | 1953 | 1953 |
| Marcellos | Kosovo | Albania | 1953 | 1953 | 1953 | 1953 |
| Yes | 1953 - | 527-08-051 | President | 1953 | 1953 | 1953 |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07395 | | | |
|--|---------|---|--|---|--|---|--|---|--|---|-----|------------|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | Day | Year | 2b. HOUR |
| Janet | | | | | | Rubin | | 5-21-69 | | 12:00 | | am | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | White | 4-1-1933 | | 36 YRS. | | | | | | 5 21 69 | | 12:20 am M | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| N.Y.C./ | | U.S.A. | | | | Prince George's | | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| Bowie | | 2410 Sudberry Lane | | Housewife | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Prince George's | | Bowie | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2410 Sudberry Lane | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | |
| Abraham Chernow | | | | | | | | Rose Spitzer | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT | | ADDRESS | | | | | | | |
| | | | | Israel Rubin, Husband, | | 2810 Sudberry Lane | | | | | | Bowie, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u>
4123
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerotic heart disease</u>
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes
unknown | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED | | 5-21-69 | |
| ACTUAL
SIGNATURE | | EXAMINER'S
NAME (Type) | | John Kehoe MD Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 5/22/69 | | King David Mem. Garden | | Falls Church, Va. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 3501 14th St. NW | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Bernard Danzansky & Sons | | Wash., D.C. 20004 | | MAY 26 1969 | | Charles Judge | | | | | | | |

07403



1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|------------------------------|---|---|---|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 07396 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| STAFFORD | | | W SAUL | | | Month 5 Day 3 Year 67 | | | 759 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| male | | white | | 7-22-31 | | | 37 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| Wash D.C. | | U.S. | | | | | Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Clinton | | | Clinton Community Hosp | | | Contractor | | | Electrical | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | | PG | | Clinton | | | | Clinton Md
11214 Brandywine Rd | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Albert F. Saul | | | | | Elsie A. Harvey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | |
| no | | | | | Anna L. Saul | | | 11214 Brandywine Road, Clinton, Md., 20735 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 770 surgical infection | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardio-vascular | | | | | | | | | 3 wks | |
| DUE TO, OR AS A CONSEQUENCE OF (c) UNK. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| Hypertension | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| | | | | | | | | YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-30, 1969, to 5-3, 1969, that (I) (we) last saw the deceased alive on 5-3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| | | | | | | | | | 5/4/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| ROBERT W. MEAKLE | | | | | 7945 WOODWARD RD CLINTON MD | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 5/7/69 | | Cedar Hill | | | Suitland, Maryland | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert E. Wilhelm Funeral Home | | | | | 4308 Suitland Rd., S.E., Suitland, Md., 20023 | | MAY 8 1969 | | Charles Judge | |

02403

RECEIVED

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07404

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07397

| | | | | | | | |
|---|--------------|---|------------------|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print) | | First
Carl | Middle
Cloyce | Last
Scott Jr. | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5 10 19 69 | | 2b. HOUR
1:50 PM |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
27 Mar 1947 | | 6. AGE (in years
lost birthday)
22 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month 5 Day 10 Year 19 69 |
| 7a. BIRTHPLACE (State or foreign
country)
N. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George | |
| 10. CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Leland Hosp | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR
INDUSTRY
U. of Md. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Greenbelt | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
8549 Glendale Rd. | | 14. FATHER'S NAME
First Middle Last
Carl C. Scott Sr. | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Theresa McNeill | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
ADDRESS
Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Laceration of brain
8147
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } Trauma Auto Accident 5 min.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
1:45am 5 10 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Pedestrian struck by car. | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
workplace, office building, etc.)
9100 Block Baltimore Ave., | | 21f. LOCATION Street or R.F.D. No.
College Park | | City or Town
P. G. Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type) | | John Kehoe, M.D., Riverdale | | | | 22b. DATE SIGNED
5-10-69 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5-13-69 | | 23c. NAME OF CEMETERY OR CREMATORY
McNeill Family Cem. | | 23d. LOCATION (City or Town) (County) (State)
West Jefferson, Ashe, N. C. | |
| 24. FUNERAL DIRECTOR
ADDRESS
Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

30450

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|-------------------------------------|--|--|--|--------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 07405 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 07398 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Hattie Idella Selby | | | | | | | | | | | | 2a. DATE OF DEATH
5 Month 3 Day 69 Year | | | | | | | | | | | | 2b. HOUR
11:30 A.M. | | | | | | | | | | | |
| 3. SEX
Female | | | | 4. RACE
White | | | | 5. DATE OF BIRTH
Dec. 18, 1881 | | | | 6. AGE (In years last birthday)
87 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Prince Georges Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheltenham | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
-- | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret'd School Teacher | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Schools | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | 13b. COUNTY
Pr. Geo's | | | | 13c. CITY OR TOWN
Cheltenham | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
-- | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Joseph A. Selby | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Martha -- Pyles | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No
(If yes give war or dates of service) -- | | | | | | 16b. SOCIAL SECURITY NO.
-- | | | | | | 17. INFORMANT
950 North Hill Road
Wm. J. Pyles-Baltimore, Md. 21218: | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Syst
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May, 1964 , to May, 1964 , that (I) (we) last saw the deceased alive on April 5, 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
A. Clark Holmes, M.D. | | | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
5/3/69 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
A. Clark Holmes, M.D. | | | | | | | | | | | | 22e. ADDRESS
Upper Marlboro, Md. 20870: | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | 23b. DATE
5/5/69 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Cheltenham Meth. Cem. | | | | | | 23d. LOCATION (City or Town) (County) (State)
Cheltenham Pr. Geo Md. | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Ritchie Bros. Upper Marlboro, Md. | | | | | | | | | | | | ADDRESS | | | | | | 25a. REG'D BY REGISTRAR
MAY 13 1969 | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | | | |

03402

Hattie Idealia Selby

Female White Dec. 18, 1881 07

Married U. S. A. Prince Georges

Charlottesville -- Back School Teacher, Charlottesville

Mr. Geo. A. Charlton X --

Joseph A. Selby --

20 North Hill Road
New York City, N.Y. 10011

A. Clark Holmes, D.D.

Upper Marlboro, Md. 20785

April 5/09

Charlottesville, Va. 22902

Richie from Upper Marlboro, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Carlesburg, John H. & Mary V. Vignola

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|
| 07406 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07399 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Luther Anderson Senter | | | | | | | | | | 2a. DATE OF DEATH
5 Month 3 Day 1969 Year | | | | | | | | | | 2b. HOUR
11 P. M. | | | | | | | | | |
| 3. SEX
male | | | | | 4. RACE
white | | | | | 5. DATE OF BIRTH
April 7, 1882 | | | | | 6. AGE (In years last birthday)
87 YRS. | | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Lincoln Co. N.C. | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH
Prince Georges Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Clinton, Md. | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Clinton Community Hosp. | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
retired yard foreman | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Gate Master | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | | 13b. COUNTY
Prince Georges Co. Clinton | | | | | 13c. CITY OR TOWN
Clinton | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER
5609 Ramblewood Ave. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Epherian - Senter | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Unknown | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT
Herbert L. Turner | | | | | Address
Clinton, Md.
5609 Ramblewood Ave. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC CVD
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 MIN
> 6 MOS | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
EXTREME OLD AGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 1968, to DEATH, 1969, that (I) (we) last saw the deceased alive on 2/25/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE
Robert W. Merkle MD | | | | | | | | | | 22c. DATE SIGNED
5/13/69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT W. MERKLE MD | | | | | | | | | | 22e. ADDRESS
CLINTON HOSP, CLINTON MD | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
5-6-1969 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn Cemetery | | | | | 23d. LOCATION (City or Town) (County) (State)
Charlotte North Carolina | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home
4308 Suitland Road Suitland Maryland | | | | | | | | | | 25a. REC'D BY REGISTRAR
MAY 8 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
John Charles Jones | | | | | | | | | | | | | | |

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4308 National Road, Springfield, Maryland
Robert E. Williams, President
2-2-1959
Forest Lawn Cemetery
Charlotte
North Carolina

07407

CERTIFICATE OF DEATH

07400

| | | | | | | | | | | |
|---|--|---|---|---|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Edward J. Sharkey | | | 2a. DATE OF DEATH
Month May Day 3 Year 1969 | | | 2b. HOUR
2:10 PM | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
6/17/1900 | | 6. AGE (In years
last birthday)
68 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country)
New York City, N.Y.-U.S.A. | | | 7b. CITIZEN OF WHAT COUNTRY?
N.Y.-U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Prince Georges Md. | |
| 10. CITY OR TOWN OF DEATH
Adelphi, Maryland | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
1801-Metzerott-Rd.,
Manor Care, Adelphi | | | 12a. USUAL OCCUPATION (Kind of work done
most of working life)
Supt. of Buildings. Real Estate | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | | 13b. COUNTY
Prince Georges-Riverdale | | | 13c. CITY OR TOWN
Riverdale | | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
5309 Riverdale Road | | | 13f. APT. OR BOX NO.
Apt 201 | | | 13g. STREET AND NUMBER
5309 Riverdale Road | | | 13h. APT. OR BOX NO.
Apt 201 | |
| 14. FATHER'S NAME
First James Middle J. Last Sharkey | | | 15. MOTHER'S MAIDEN NAME
First Martha Middle Shaw Last Shaw | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, as (or unknown) (If yes, give war or dates of service)
Yes W.W. I | | | 16b. SOCIAL SECURITY NO.
061-01-1788 | |
| 17. INFORMANT
1801-Metzerott Rd
Adelphi, Maryland | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
4379
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Central Arteriosclerosis
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/19 , 19 69 , to 5/3 , 19 69 , that (I) (we) last
saw the deceased alive on 5/3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Allan Cohan, M.D. | | 22c. DATE SIGNED
5/8/69 | | | 22d. PHYSICIAN'S
NAME (Type) Allan Cohan, M.D. | | | | | |
| 22e. ADDRESS
Silver Spring, Maryland | | 22f. ADDRESS
13515 Georgia Ave. Suite 2 | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
5/6/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Hyattsville, Md. | | | | | 25a. RECEIVED BY REGISTRAR
MAY 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Francis Gasch | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|---------|-----------------------------|--|--|-----------------|---|-----------------|---|---|--|----------------------------|------------------------|--|
| <div>07408</div> <div>07401</div> <h2>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2> | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| Raymond | | | L. | | Sheets Sr. | | | | <input type="checkbox"/> Month <input checked="" type="checkbox"/> 5 Day 29 Year 1969 | | 11:20 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| Male | White | 5 May 1942 | | 27 YRS | MONTHS DAYS | | HOURS MIN. | | Month 5 Day 30 Year 1969 | | 12:00 AM | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Penn. | | | U. S. A. | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Prince George | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTE (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Riverdale | | | Eugene Leland Memorial | | | Salesman | | | Coke Cola Co | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | |
| Md. | | | Prince George | | | College Park | | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | 9302 Cherry Hill Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Woodrow W. | | | Betty | | | | | | | | | Perry | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| Yes | | | 1961 - 1964 | | | 163 34 7055 | | | Shelva J. Sheets | | | Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Laceratio of brain</u>
<u>8122</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Traums motor vehicle accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | Min | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | 11:20 AM 5 29 1969 | | | | Driver of motorcyle which struck rear of | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or town County State | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | Street | | | | an auto
9500 Block Baltimore Bvd College Park | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe, M.D., Riverdale | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5-30-69 | | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS(Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 6/2/69 | | George Washington | | | | Hyattsville P.G. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Francis Gasch's Sons | | | | | | Hyattsville, Md. | | | DATE JUN 4 1969 | | Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
45M - 11-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| First Middle Last | | | Month Day Year | | | 10:15 P.M. | | | | |
| 3. SEX
Male | | | 4. RACE
Negro | | 5. DATE OF BIRTH
7/15/18 | | 6. AGE (In years last birthday)
50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
South Carolina | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges | | | |
| 10. CITY OR TOWN OF DEATH
Glenn Dale | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Glenn Dale Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY
-- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
D.C. | | | 13b. COUNTY
138. COUNTY | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
622 7th Street, N.E. | |
| 14. FATHER'S NAME
First Middle Last
Doc Shirley | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Viola Newman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
248-18-7575 | | 17. INFORMANT
Decedent <i>nena Shirley, wife</i> Address <i>same</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause pertinent for Part 1b and 1c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant lymphoma, lymphocytic type (lympho-sarcoma) generalized
DUE TO, OR AS A CONSEQUENCE OF
(b) 2001
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Pulmonary tuberculosis | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mo. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary tuberculosis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from 12/11/ , 19 68 , to 5/5/ , 19 69 , that we (we) last saw the deceased alive on 5/5/ , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Moe Weiss</i> | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/5/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Moe Weiss, M.D. | | | | | 22e. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5-10-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Landover, Prince George, Md. | | | | |
| 24. FUNERAL DIRECTOR
Hall Bros. Funeral Home 621 Fla., Ave. N.W., Wash. DC | | | | | 25a. REC'D BY REGISTRAR
MAY 8 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

10:12

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07410

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07403

| | | | | | | | | | |
|---|--|--|--------|---|--|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| Dorothy MARIE | | Shollenberger | | | May 12, 1969 | | 4:10 | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
12-16-17 | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. AMERICA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
HOMEMAKING | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. CITY OR TOWN
Prince George's Suitland | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7437 Keystone Lane | | | |
| 14. FATHER'S NAME
First Middle Last
WILLIAM F. MANUEL | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARJORIE PEACHER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
ROSLYN SHOLLENBERGER | | Address
SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cerebella infarct</u>
4122 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 11, 1969, to May 12, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 12, 1969, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Luis Bentolila | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type)
Luis Bentolila, M.D. | | | | | 22e. ADDRESS
Prince George's Gen. Hosp. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MAY 15, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
FORD LINCOLN CEM. | | | 23d. LOCATION (City or Town) (County) (State)
COLMAR MARYLAND PRINCE GEORGES | | |
| 24. FUNERAL DIRECTOR
W.W. CHAMBERS CO. | | | | | ADDRESS
RIVERDALE, MD. | | 25a. REC'D BY REGISTRAR
DATE MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

07418

INSTRUMENT

07418

Locality NAME

NO. 10, 100

Location

White

10 10-10

10

W. A. Smith

Chemistry

Radioactive

Radioactive

W. A. Smith

W. A. Smith

NO.

10 10-10

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Radioactive

Radioactive

NO.

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W. A. Smith

W. A. Smith

Radioactive

Radioactive

W. A. Smith

W. A. Smith

W. A. Smith

W. A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07411 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07404 | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| Item#8Film#G412 5/21/69 vpw | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Thelma M. Shorter | | | | 2a. DATE OF DEATH
Month May Day 14 , Year 1969 | | | | 2b. HOUR
M | | | |
| 3. SEX
Female | | 4. RACE
Can. | | 5. DATE OF BIRTH
Feb. 21, 1909 | | 6. AGE (In years lost birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Brandywine | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rt 1 Box 47 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housework | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Brandywine | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Rt 1 Box 47 | | | |
| 14. FATHER'S NAME
First John Middle Brooke Last | | | | 15. MOTHER'S MAIDEN NAME
First Alice Middle Last Selby | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
 | | 17. INFORMANT
Address Jeanne Fox, La Plata, Md. 20646 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Cancer
1829
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause
(b) Post hysterectomy of for Cancer of Uterus.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pneumonia both sides. | | | | | | | | | | | |
| 19a. DATE OF OPERATION
 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
 | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
 | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
 | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/21, 1968 , to 5/15, 1969 , that (I) (we) last saw the deceased alive on 5/12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
N. Bhaduri MD | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/15/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Niren N. Bhaduri | | | | 22e. ADDRESS
Waldorf, Maryland 20601 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Huntt Funeral Home, Waldorf, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

07411

May 1, 1980

Director

Division

Form 1

Can.

Jan. 1, 1980

Personnel

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Investigation

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|--|-------------------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07412 | | | | | 07405 | | | | |
| 1. DECEASED-NAME | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| First Middle Last | | | | | Month Day Year | | | HOURS MIN. | |
| Sanford Yokum Y. Simmons | | | | | 5 18 69 | | | 8:00aM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | caucasian | | Dec. 2, 1892 | | 76 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Rig. W. Va. | | U.S.A. | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly, Md. | | Prince George's Gen. Hosp. | | Retired Car Man | | B. & O. R.R. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | U.S.A. | | Brandywine | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Rte. 3 Box 270 Brandywine | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Jethro G. Simmons | | | Magdalena Pratt | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | No | | Mrs. Wm. N. Bingman Brandywine, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of the right colon with metastases | | | | | | | | Many months | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| Arteriosclerotic heart disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 4/14/69; 5/14/69 | | Carcinoma resection; Pericardial Fat | | Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/26, 1969, to 5/18, 1969, that (I) (we) last saw the deceased alive on 5/18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Frederick H. Wilhelm M.D. | | | | | | | | 5/18/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Frederick H. Wilhelm M.D. | | | | 6319 Landon Road; Cheverly, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5-21-69 | | Newhouse Cemetery | | Rig. W. Va. | | Hardy | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Harold W. McKenzies | | | | Keyser, W. Va. | | MAY 22 1969 | | Charles Judge | |

01510

London 10/11/40

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 10th inst.

in relation to the above mentioned matter.

I am sorry to hear that you are unable to supply the information requested.

I am sure that you will be able to supply the information requested in the future.

I am sure that you will be able to supply the information requested in the future.

I am sure that you will be able to supply the information requested in the future.

I am sure that you will be able to supply the information requested in the future.

I am sure that you will be able to supply the information requested in the future.

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I am sure that you will be able to supply the information requested in the future.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07413

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07406

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Helen W. Simms | | | 2a. DATE OF DEATH
Month Day Year
May 18, 1969 | | 2b. HOUR
4:35 P. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
8/27/1895 | 6. AGE (In years last birthday)
73 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Wash., D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Prince George's Md. | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's Gen. Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret.- R.E.A. | 12b. KIND OF BUSINESS OR INDUSTRY
- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | 13b. COUNTY
Prince George's | 13c. CITY OR TOWN
Mt. Rainier | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
2901 Arundel Rd. | |
| 14. FATHER'S NAME
First Middle Last
George Warwick | 15. MOTHER'S MAIDEN NAME
First Middle Last
Margaret Drisoll | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, go, or (unknown) No | 16b. SOCIAL SECURITY NO.
714-03-2698 | 17. INFORMANT
Address 6639- 24th Pl., W.Hy., Md.
Hazel Wirsching- | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>
<u>492X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Acute Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Chronic Bronchial Asthma Exacerbation</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>2 weeks</u>
<u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1966</u> , 1966, to <u>5-18</u> , 1969, that (I) (we) last saw the deceased alive on <u>5-18</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type)
J. SAKAKI | | 22e. ADDRESS
6001 Landover Rd. (Clara) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
5/21/69 | 23c. NAME OF CEMETERY OR CREMATORY
Glenwood Cemetery | 23d. LOCATION (City or Town) (County) (State)
Wash., D.C. | | |
| 24. FUNERAL DIRECTOR
Valley's Funeral Home Inc. | | ADDRESS
Mt. Rainier Maryland | 25a. REC'D BY REGISTRAR
MAY 23 1969 | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

07410

5/27/1965

Prince George's

Prince George's County, Md.

Prince George's County, Md.

Prince George's County, Md.

Prince George's County, Md.

Prince George's County, Md.

5/27/65

MAY 27 1965

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME
(Type or Print) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | | | |
|---|--|---------|--|--|--|---------------------------------|--|--|--|---|--|---|--|------------------------|--|--|--|
| Annie Louise Simpson | | | | | | | | | | Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 5-25-69 | | 11:00am | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | |
| Female | | White | | 6-7-1914 | | 54 YRS. | | MONTHS | | DAYS | | Month 5 Day 25 Year 69 | | 12:17pm | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | |
| Md. | | | | U.S.A. | | | | | | | | Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | | | Prince George Hospital | | | | Housewife | | | | Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Prince George's | | | | Oxon Hill | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7891 Locust Lane | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Alvin Lee Moore | | | | Blanche I. Ball | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | | | |
| no | | | | 578 01 3592 | | | | Audrey E. Mercillott 5408 Hamilton Street Hyattsville, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute hepatitis | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (b) and hemorrhagic pancreatitis | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | HOUR A.M. 19 P.M. | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER | | | | 5-26-69 | | | | | | | | | |
| John Kehoe MD | | | | DEPUTY MEDICAL EXAMINER | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| Riverdale, Md. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 5/28/69 | | | | Ft. Lincoln | | | | Colmar Manor P.G. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Francis Gasch's Sons | | | | JUN 2 1969 | | | | Hyattsville, Md. | | | | | | | | | |

03478

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07415

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07408

| | | | | | | | |
|---|---------|--|--------|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR |
| Ralph Melville Simpson | | | | | 5-17-69 19:00pm | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| Male | White | April 2, 1905 | | 64 YRS. | 5 Month 17 Day 69 Year 19:00pm | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U. S. A. | | | | Prince George's Md | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | Prince George Hospital | | Cattle Farming | | Own Farm | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Prince George's | | Upper Marlboro | | 2301 Largo Road | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First Middle Last |
| Albert Thomas Simpson | | | | | Sarah -- Thomson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | Mrs. Charlotte L. Simpson Hagen- | | Same as 13-B 13-C | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple pulmonary emboli
819.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 5-2-69 | | Subdural hematoma | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | |
| | | 1:24pm 5-2- 1969 | | Automobile accident | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town County State | |
| | | Rosaryville Road, Prince | | George County, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| John Kehoe MD | | Riverdale, Md. | | | | 5-19-69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 5/20/69 | | Trinity Cemetery | | Upper Marlboro Pr. Geo. Md | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. RECD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Ritchie Bros. Fun'l Home- | | Upper Marlboro Md. 20870: | | MAY 23 1969 | | Charles Judge | |

07413

Religion

April 2, 1903

Marriage

U. S. A.

Catholic Training

X

Albert Thomas Simpson

John

Rev. Charles L. Simpson

NO

...

2/20/03

Trinity Cemetery

Rev. ...

Rev. ...
Upper ...
20370

Upper ...

1538
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--------------------------------|---|---|--|--|--|-------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07416 CERTIFICATE OF DEATH 07409 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) ELIZABETH | | | First Middle Last SMITH | | | 2a. DATE OF DEATH
MAY Month 1 Day 69 Year | | | 2b. HOUR 1:30 PM |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
14 Jan 39 | | 6. AGE (In years birthday)
30 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
PRINCE GEORGES Md. | | | |
| 10. CITY OR TOWN OF DEATH
ANDREWS AFB | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MALCOLM GROW USAF HOSP | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission to State)
VIRGINIA | | 13b. CITY OR TOWN
FAIRFAX | | 13c. CITY OR TOWN
ALEXANDRIA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8004 ASHBORO DR | |
| 14. FATHER'S NAME First Middle Last
JOSEPH EDWARD OSHMAN | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ANNA EVELYN ETRO | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)
NO | | | | 16b. SOCIAL SECURITY NO.
193-30-1922 | | 17. INFORMANT (Husband) Address
Donald Smith Same as item # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1538
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adenocarcinoma of colon
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 mths
10 mths | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept , 19 68 , to 1 May , 19 69 , that (I) (we) lost the deceased alive on 1 May , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David Rosenthal | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
1 May 69 | |
| 22d. PHYSICIAN'S NAME (Type)
DAVID ROSENTHAL, MAJ USAF MC | | | | | | 22e. ADDRESS
MALCOLM GROW USAFHOSP ANDREWS AFB | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-5-69 | | 23c. NAME OF CEMETERY OR CREMATORY
All Saints Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Chesapeake Prince Anna | | | |
| 24. FUNERAL DIRECTOR
W. W. Chamber | | | | ADDRESS
517-115 St. S.E. | | 25a. REC'D BY REGISTRAR
MAY 8 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

0716

RECEIVED

ELIZABETH SMITH MAY 1 1952

10 Jan 52

PENNSYLVANIA U.S.A. X PRINCE GEORGE

ANDREWS AFB MALCOLM GROW USAF HOSP HOUSTON TX

VIRGINIA FAIRFAX ALEXANDRIA X 3004 RASHBURN DR

JOSEPH EDWARD OSHMAN ANNA EVELYN ETRD

(Husband)

107-1-1952 Donald Smith Same as item 4 13

NO

DAVID ROSENTHAL MAL USAF MC MALCOLM GROW USAF HOSP ANDREWS AFB

1 May 52

0092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|
| 07417 CERTIFICATE OF DEATH 07410 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Harvey A. Smith | | | 2a. DATE OF DEATH
Month May Day 20 Year 1969 | | | 2b. HOUR 9:40 PM | | | |
| 3. SEX
Male | | 4. RACE
Caucasion | | 5. DATE OF BIRTH
4/5/1904 | | 6. AGE (In years last birthday)
64 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH
Riverdale, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
E. Leland Mem. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Steamfitter | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Landover | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1600 Annapolis Ave. | |
| 14. FATHER'S NAME
First Alonzo Middle W. Last Smith | | | 15. MOTHER'S MAIDEN NAME
First Roxanna Middle Dozier | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO.
229-10-7630 | | 17. INFORMANT
Harvey E. Smith | | Address
406 Maple St., Manassas, Virginia | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
009.2 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastro-Intestinal Bleeding 5 days
DUE TO, OR AS A CONSEQUENCE OF (c) Jejunitis, at Porton 6 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION
17 May 1969 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Gastro-Intestinal Bleeding | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4 May , 1969, to 20 May , 1969, that (I) (we) last saw the deceased alive on 20 May , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Ths M. Hutchins | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-20-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas M. Hutchins | | | | 22e. ADDRESS
7315 Landover Rd. Hyattsville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Bladensburg, Maryland | | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home | | | | 25a. REC'D BY REGISTRAR
MAY 26 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |
| 4308 Suitland Road, S.E., Suitland, Md., 20023 | | | | | | | | | |

07613

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DATE OF DEATH: 10/10/1968

NAME: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 07418 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07411 | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Clara D. Speight | | | | | | | | | | 2a. DATE OF DEATH Month 5 - Day 27 - Year 1969 | | | | | | | | | | 2b. HOUR 6 P M | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | 4. RACE Caucasian | | | | | 5. DATE OF BIRTH 12-20-10 | | | | | 6. AGE (In years last birthday) 58 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) North Carolina | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Prince Georges Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH RIVERDALE | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LELAND MEM HOSPITAL | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | | 13b. COUNTY Prince Georges | | | | | 13c. CITY OR TOWN Beltsville | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER 4418 Greenwood Road | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Jonas C. Dilda | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Almeda Killebrew | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 578202050 | | | | | 17. INFORMANT JAMES L. SPEIGHT, 4504 SAMAR ST. BELTSVILLE, MD | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 DAYS | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE | | | | | | | | | | | | | | | UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) DIABETES MELLITUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 APR. 1969, to 27 MAY, 1969, that (I) (we) last saw the deceased alive on 27 MAY 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE C.J. Houmann | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 27 MAY 1969 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) C.J. HOUMANN M.D. | | | | | | | | | | 22e. ADDRESS RIVERDALE MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | | | | | 23b. DATE 30 MAY 1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM GARDENS | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) WILSON N. CAROLINA | | | | | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co. | | | | | | | | | | ADDRESS 5801 Old Bridge Ave Riverdale Md | | | | | | | | | | 25a. REC'D BY REGISTRAR JUN 2 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|---|--|---------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07419 | | | | | 07412 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Eva NMI Spengler | | | | | Month 5 Day 3 Year 1969 | | 2b. HOUR | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | | White | | 9/7/93 | | 75 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| VA. | | USA | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | Prince George's Gen. Hosp. | | Clerical Clerk | | U.S. Gov't | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Prince Geo. | | Lanham | | | | 6212 Princess Garden Pkwy | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| William E. O'GRAY | | MARY BOWLER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | No | | 213-48-0530 MRS. JANE PRITZ Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| Hour A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-2-69, 1969, to 5-3-69, 1969, that (I) (we) last saw the deceased alive on 5-3-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| A. Deitz | | 5/3/69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Aaron Deitz, M.D. | | East-West Highway, Hyattsville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | MAY 6, 1969 | | F.T. LINCOLN Cem | | Bladensburg, Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| LANHAM FUNERAL HOME | | MAY 7 1969 | | Charles Judge | | | | | |
| LANHAM, MARYLAND | | | | | | | | | |

0713

RECEIVED

STATION

DATE

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WATTS

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|--|--|---|--|---|---|---|--|--|
| <div>07420</div> <div>07413</div> | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| Wilda Jeanette Stewart | | | | | | MATED <input checked="" type="checkbox"/> 5-27-69 1911 | | 00am | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | |
| Female | White | 6-22-1917 | 51 YRS. | | | | | Month Day Year
5 27 69 19 4:00pm | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Canada | | U.S.A. | | | | Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | 2800 Crest Avenue | | | Housewife | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | Prince George's | | Cheverly | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2800 Crest Avenue | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| William Cowan | | | Lola Chilton | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| no | | | none | | George M. Stewart Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hanging</u>
953X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
11:00am 5-27-69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Hung self at home | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | same as #13 | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 5-28-69 | | | | |
| John Kehoe MD Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 5/29/69 | | Ft. Lincoln | | Colmar Manor P.G. Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis Gasch's Sons Hyattsville, Md. | | | | | DATE JUN 2 1969 | | Charles Judge | | | |

4339

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|---------------------------------|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) JAMES | | | First M Middle THOMAS Last | | | 2a. DATE OF DEATH
Month MAY Day 13 Year 1969 | | | 2b. HOUR
M |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
JUNE 17 1896 | | 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS
IF UNDER 24 HRS.
HOURS
MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH
Chesley | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5600 Monroe Street | |
| 14. FATHER'S NAME First T. Middle E. Last THOMAS | | | 15. MOTHER'S MAIDEN NAME First Ida Middle - Last MORRISON | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
578 03 9863 | | 17. INFORMANT
Julia M. Thomas | | | Address
SAME AS ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
4330
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis, cerebral
DUE TO, OR AS A CONSEQUENCE OF
(c) Arteriosclerosis, general | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hours
Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Hypertension, essential. Uremia secondary chronic obstructive urinary tract disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 25 May, 1963 , to 13 May, 1969 , that (I) (we) last saw the deceased alive on 12 May, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John F. Brennan MD | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
13 May 69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/16/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor, Md. | | | |
| 24. FUNERAL DIRECTOR
Nalley's Funeral Home | | | | ADDRESS
Mt Rainier, Md | | 25a. REC'D BY REGISTRAR
DATE
MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

1887

STATE OF NEW YORK

IN SENATE

1887

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

AT ITS SESSION ON JANUARY 14, 1887

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1887.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| 07422 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07415 | |
|---|---|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Prince George's</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Washington D.C.</i> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Clinton</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Washington, D.C.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Pine View Gardens Health Care Center</i> | | d. STREET ADDRESS
<i>1349 Harvard St. N.W.</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<i>Eva Thompson</i> | | 4. DATE OF DEATH
Month <i>May</i> Day <i>14</i> Year <i>1969</i> | | | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>N.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>May 6, 1907</i> | 9. AGE (In years last birthday)
<i>62</i> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>NONE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Clinton, S. Carolina</i> | |
| 13. FATHER'S NAME
<i>Willie Jack Shepherd</i> | | 14. MOTHER'S MAIDEN NAME
<i>Mattie Cornelia Dunlap</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO.
<i>NONE</i> | | 17. INFORMANT
<i>Jerry Mathews</i> Address <i>1436 W. St. N.W. Washington, D.C.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>4122</i> IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>
DUE TO (b) <i>Coronary insufficiency</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Arteriosclerosis</i>
<i>Cerebrovascular accident</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Cerebrovascular accident</i> | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>May 6, 1969</i> to <i>May 18, 1969</i> that (I) (we) last saw the deceased alive on <i>May 18, 1969</i> , and that death occurred at <i>3:00</i> P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Alfred R. Lapin</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<i>ALFRED R. LAPIN</i> | | 22d. ADDRESS
<i>CLINTON, MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | 23b. DATE THEREOF
<i>5-17-69</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>HARMONY PK.</i> | 23d. LOCATION (City or Town) (County) (State)
<i>LANDOVER, MD.</i> | | |
| 24. FUNERAL DIRECTOR
<i>Rollins, Inc. 4339 Hunt Pl. N.E. D.C.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 19 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|------------------|--|--------|--|-------|--|
| 07423 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07415 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | | |
| First | | Middle | | Last | | Month | | Day | | Year | | Hours | | Min. | |
| Eugenia | | Letitie | | Tirendi | | May | | 19 | | 1969 | | 12:50 | | A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| Female | | White | | 12-24-90 | | 78 | | YRS. | | MONTHS | | DAYS | | HOURS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | Md. | |
| Italy | | U.S.A. | | | | Prince George's | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Cheverly | | Prince George's Gen. Hosp. | | Housewife | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| MD | | Prince George's | | Lanham | | | | 7707 Cross Street. | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| Michael | | Candido | | | | | | Mary | | Ganci | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | | |
| No | | | | | | Mary T. Kearney - above address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 450X | | Acute pulmonary emboli, bilious | | (Daughter) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | Minutes | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | (c) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | Pernicious anemia. Old Fractured Hip | | Hypothyroid. Recent pneumonia. Acute colitis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/9, 1964, to 5/19, 1964, that (I) (we) lost saw the deceased alive on 5/19, 1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Frederick H. Wilhelm MD | | 22c. DATE SIGNED 5/19/64 | | 22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm | | 22e. ADDRESS 6314 Lmlover Road, Cheverly Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition of body Burial | | 23b. DATE 5/22/69 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City or Town) (County) (State) Waterbury, Conn. | | | | | | | | | |
| 24. FUNERAL DIRECTOR Valley's Funeral Home Inc. | | ADDRESS Mt. Rainier, Maryland | | 25a. REC'D BY REGISTRAR MAY 23 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |

20450

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Julia Frances Tolson | | | | | 2a. DATE OF DEATH Month Day Year
May 14 1969 | | 2b. HOUR
3:10A | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 28, 1893 | | 6. AGE (In years last birthday)
75 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Washington D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince Geo. Gen Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Ret. Food Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital Cafeteria | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Hattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
5305 Chesapeake Road | |
| 14. FATHER'S NAME First Middle Last
William Healey | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Elizabeth Ward | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
no | | | 16b. SOCIAL SECURITY NO.
579 03 2440A | | 17. INFORMANT Address
Carl E. Tolson Same as #13 (husband) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal obstruction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Carcinoma of the Pancreas with metastases
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 weeks
5 months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic heart disease and cerebrovascular disease | | | | | | | | | | |
| 19a. DATE OF OPERATION
5/12/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Intestinal obstruction | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)
<input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/26 , 19 69 , to 5/14 , 19 69 , that (I) (we) last saw the deceased alive on 5/14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Frederick H. Wilhelm | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
4/14/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Frederick H. Wilhelm, M.D. | | | | | 22e. ADDRESS
6319 Lindover Road, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/16, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National | | 23d. LOCATION (City or Town) (County) (State)
Suitland P. G. Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Francis Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR
MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

03232

STATE OF NEW YORK

IN SENATE
JANUARY 1, 1914

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1913

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS, 1914.

THE STATE OF NEW YORK
OFFICE OF THE COMMISSIONER OF THE LAND OFFICE
ALBANY, N. Y.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1913

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

07425

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07418

| | | | | | | | | | | |
|--|---------|---|----------|---|---|--|--------------------------|---|---------------------------------------|---|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Lost | 20. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 5-13-69 | | Month | Day | Year | 2b. HOUR |
| Alice | | E | Treleven | | | 19 | | 6 | 15pm | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years
last birthday) | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
DAYS | | 2c. DATE PRONOUNCED DEAD
Month | |
| Female | White | 3-30-1893 | | 76 YRS. | | | | | Day 13 69 ^{year} 19 6:30pm M | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Kentucky | | U.S. | | Prince George's | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Suitland | | | | Andrews Air Force Base Hosp. | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| District Of Columbia | | | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6200 Oregon Ave. N.W. | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle | Lost | |
| UNKNOWN | | FRAMPTON | | | UNKNOWN | | BURKE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| No | | | | 340-14-8336 | | CAROL ROSENZWEIG | | 1234 CEDAR HILL LANE Broomfield Hills, MICH. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart failure</u>
<u>4123</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes
over 10 yr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, form, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL
SIGNATURE | | John Kehoe MD | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S
NAME (Type) | | John Kehoe MD Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 5-14-69 | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| CREMATION | | 15 MAY 1969 | | CEDAR HILL CREMATORY | | SUITLAND MD. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| RINALDI FUNERAL HOME | | 7400 GEORGIA AVE. N.W. DC | | 20012 MAY 19 1969 | | William Judge | | | | |

07452

FOR INFO
PLEASE ONLY

REDACTED INFORMATION IS DECLASSIFIED

DATE

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535X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | |
|---|--|--------------------------------|--|--|--|------------------------------------|--|--|--|---|--|--|--|-------------------|--|
| 07426 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07419 | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | | | 2b. HOUR | |
| Nellie | | | | May | | Umstead | | May 16, 1969 | | | | 5:45 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years and birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | May 16, 1882 | | | | 87 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? * | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md. | | | |
| Penna. | | U.S.A. | | | | Prince George's | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | | | Prince George's Gen. Hosp. | | | | Housewife | | | | --- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | | | Prince George's | | Bowie | | | | 12315 Whitehall Drive | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First Middle Last | |
| Martin | | | | Rahm | | | | | | Martha Coulter | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | | | | |
| No | | --- | | 291-20-2382 | | | | Mildred Marin (daughter) Same AS # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Massive G.I. Bleeding</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) <u>Acute Gastritis associate with granulomatous Colitis</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 11, 19 68</u> , to <u>May 16, 19 69</u> , that (I) (we) last saw the deceased alive on <u>May 14, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | | | | | | |
| <u>Leonard P. Appel</u> | | | | 5/18/69 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | | | | | | |
| Leonard P. Appel, M.D. | | | | 3231 Superior Lane, Bowie, Md. 20715 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | | 5-21-1969 | | West Park Cemetery | | | | Cleveland, Ohio | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <u>W. W. Chambers Co.</u> | | | | <u>Buwerdelo, Md.</u> | | | | MAY 20 1969 | | <u>Francis Judge</u> | | | | | |

07452

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

Washington, D. C.

February 1, 1917

Dear Sir:

I have the honor to acknowledge the receipt of your letter of January 31, 1917, in relation to the matter of the proposed amendment to the act of August 1, 1914, relating to the control of the export of certain commodities.

The proposed amendment is being considered by the Bureau of Plant Industry, and it is expected that a decision will be reached within a few days.

I am, Sir, very respectfully,
Very truly yours,
[Signature]

Special Agent in Charge

U. S. Department of Agriculture

Washington, D. C.

Enclosed for you are two copies of the proposed amendment.

1539

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|---|--|---|------|--|--|---|--|
| 07427 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07428 | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
9:44 AM | |
| Elwood G. Valentine | | | | | | 5 19 69 | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
July 19, 1886 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince Georges Md. | | | |
| 10. CITY OR TOWN OF DEATH
Accokeek | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Residence | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Wash Terminal | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
PG | | 13c. CITY OR TOWN
Accokeek | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RFD 2 Box 121 | |
| 14. FATHER'S NAME
George Valentine | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
- Campbell | | First Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
718-14-9823 | | 17. INFORMANT
Gertrude G. Mahan, Daughter
4908 Kirby Road, Clinton, Md., 20735 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Infection</u>
1539 DUE TO, OR AS A CONSEQUENCE OF <u>Cancer of Bowel</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis & Atherosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ageing</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 Day
year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-10, 1966, to 5-17, 1969, that (I) (we) lost saw the deceased alive on 5-16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Gertrude G. Mahan MD | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland, 20023 | | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm | | ADDRESS
4308 Suitland Road, S.E., Suitland, Md., 20023 | | 25a. REC'D BY REGISTRAR
DATE
MAY 22 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

01453

1944

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|---|--|---|--|--|--|--|--|---------------------------|--|---------------------------|--------------------------|--|--|--|--|--|--|--|--|
| 07428 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 07421 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
HARRY | | | Middle
FREDRICK | | | Last
VOLKMAN | | | 2a. DATE OF DEATH
Month 12 Day 69 Year | | | 2b. HOUR a
1140 M | | | | | | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
5 Jun 1898 | | | 6. AGE (In years
last birthday)
70 YRS. | | | IF UNDER 1 YEAR
MONTHS | | | IF UNDER 24 HRS.
DAYS | | | IF UNDER 24 HRS.
HOURS | | | IF UNDER 24 HRS.
MIN. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Washington DC | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
PRINCE GEORGES Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
ANDREWS AFB | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
MALCOLM GROW USAFHOSP | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
RETIRED | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
MARYLAND | | | 13b. CITY OR TOWN
PRINCE GEORGE | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER
8304 DONNELL PL #C-5 | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Harry | | | Middle
F. | | | Last
Volkman | | | 15. MOTHER'S MAIDEN NAME
First
Susan | | | Middle
Benson | | | Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
YES | | | 16b. SOCIAL SECURITY NO.
577-40-9549 | | | 17. INFORMANT
Address
Wife same as item # 13 | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) Severe pulmonary insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(c) chronic obstructive emphysema
1 Month | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 Minutes | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Severe arteriosclerosis generalized | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
24 Apr 69 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
undiagnosed pulmonary
infiltrate of ? etio. | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
no | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 Apr , 19 69 , to 12 May , 19 69 , that <input checked="" type="checkbox"/> (we) last
saw the deceased alive on 12 May , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the
cause(s) stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard Flax MD | | | DEGREE
MD | | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
12 May 69 | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
RICHARD FLAX, CAPT USAF MC | | | 22e. ADDRESS
MALCOLM GROW USAFHOSP ANDREWS AFB | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
May 16-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl. Cemetery, Arlington, Va | | | 23d. LOCATION (City or Town) (County) (State)
Wash., | | | 25a. REC'D BY REGISTRAR
MA 11 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Simmons Bros | | | | | | | | | | ADDRESS
Wash., | | | | | | | | | | DATE
MA 11 1969 | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Simmons Bros. 1661-Gd. Hope Rd. SE.DC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

HARRY FREDRICK VOLKMAN MAY 12 88

Male Caucasian 5 Jun 1888 70

Washington DC U.S.A. PRINCE GEORGE

ANDREWS AFB MALCOLM GRAY USARHOSP RETIRED

MARYLAND PRINCE GEORGE FORESTVILLE X 8304 DONNELL PL AC-2

2017

277-90-9588 Wife name as listed 13

Cardiac arrest 2 witnesses

Severe pulmonary insufficiency 1 Month

Metastatic CA of lung and chronic obstructive pulmonary

Severe arteriosclerosis generalized

24 Apr 88 undiagnosed pulmonary infarct of 1 side

no

12 May 88 2 Apr 88 13 May 88

12 May 88

RIGHT RD FLAK, CAPT USARHOSP

MALCOLM GRAY USARHOSP ANDREWS AFB

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1621

| | | | | | |
|---|--|--|-------|---|------|
| 07429 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07422 | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost |
| George | | | M. | Waterholter | |
| 2. DATE OF DEATH | | | Month | Day | Year |
| May | | | 12 | 1969 | |
| 2b. HOUR | | | 6 A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | White | | 06-10-18 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Washington, D.C. | | U.S.A. | | 9. COUNTY OF DEATH
Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Cheverly | | Prince George's Gen. Hosp. | | Construction | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | Prince George's | | District Hgt. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| George | | Martha | | 5409 Walkermill Road | |
| Waterholter | | Bell | | Rowley | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | | | Kelsey Johnson I43I Ridge Pl S.E D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiratory arrest</u>
1621
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Obstruction of right main bronchi</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>bronchogenic CA.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (this hospital) attended the deceased from May 7, 1969, to May 12, 1969, that (X) (we) lost saw the deceased alive on May 12, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Luis Bentalila</u> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Luis Bentalila, M.D. | | | | 22e. ADDRESS
Prince George's Gen. Hosp. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 5/15/69 | | Washington Natl Cemetery Suitland Maryland | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Lee Funeral Home | | MAY 16 1969 | | Charles Judge | |
| 4th & MASS AVE N.E. Washington D.C. | | | | | |

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ENTWARTING

May 12 1963

REPORT

NAME

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REMARKS

John George and John

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John George and John

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
30M REV. 4-68

| | | | | | |
|--|--|---|--|---|--|
| 07430 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07423 | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Margaret M. Weishaupt | | | | 2a. DATE OF DEATH
Month Day Year
May 15 1969 | |
| 3. SEX
Female | | 4. RACE
White | | 2b. HOUR
6:55 A M | |
| 5. DATE OF BIRTH
04-10-13 | | 6. AGE (In years last birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Wash. D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Prince George's Gen. Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Bladensburg | |
| 14. FATHER'S NAME
First Middle Last
Thomas Lavender | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Regina Murphy | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No (or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
213-54-9585 | | 17. INFORMANT
Address
Robert A. Weishaupt Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ischemic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypertension + yellow atrophy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr.</u>
<u>1 mo.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19/69</u> , 19 <u>69</u> , to <u>5/15/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5/11/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Frederick E. Musser</u>
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>5/15/69</u> | |
| 22d. PHYSICIAN'S NAME (Type)
Frederick E. Musser, MD. | | | | 22e. ADDRESS
4410 74th Ave., Hyattsville, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-17-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | |
| 23d. LOCATION (City or Town)
Bladensburg | | 23e. (County)
Maryland | | 23f. (State) | |
| 24. FUNERAL DIRECTOR
ADDRESS
<u>Francis Collins 500 Univ. Blvd. W. Sd. & Kd</u> | | 25a. REC'D BY REGISTRAR
DATE
MAY 20 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>James Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07431 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 07424 | | | | | | | | | |
| 1. DECEASED-NAME First Middle Last
, JOSEPH J WELSH | | | | | 2a. DATE OF DEATH Month Day Year
May 18, 1969 | | | 2b. HOUR a m
0945 | |
| 3. SEX
Male | | 4. RACE
Cau | | 5. DATE OF BIRTH
March 18, 1930 | | 6. AGE (In years last birthday)
39 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH
Andrews Air Force Base | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Malcolm Grow USAF Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Civil Service | | 12b. KIND OF BUSINESS OR INDUSTRY
USAF | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Upper Marlboro | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10906 Tyrone Drive | |
| 14. FATHER'S NAME First Middle Last
Joseph Welsh | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sylvia Russo | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
Yes | | 16b. SOCIAL SECURITY NO.
1948 - 1968 101-22-3340 | | 17. INFORMANT
10906 Tyrone Drive
Joan N. Welsh Upper Marlboro, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>acute myocardial infarction 2 hours</u>
(b) <u>acute myocardial infarction 2 hours</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>18 May</u> , 19 <u>69</u> , to <u>18 May</u> , 1969, that (I) (we) lost saw the deceased alive on <u>18 May</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>BURTON SACK</u> MD
DEGREE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
18 May 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
BURTON SACK, MD | | | | | 22e. ADDRESS
Malcolm Grow USAF Hospital
Andrews AFB, Washington, DC 20331 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5/21/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Resurrection Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Clinton, Md. | | |
| 24. FUNERAL DIRECTOR
Robert E. Wilhelm Funeral Home
4308 Suitland Rd., S.E., Suitland, Md., 20023 | | | | | 25a. REC'D BY REGISTRAR
MAY 22 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

071310

STATE OF TEXAS

1913

IN SENATE, January 13, 1913.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1912.

ALBINO S. HARRIS, COMMISSIONER.

PRINTED BY THE STATE OF TEXAS, 1913.

THE STATE OF TEXAS, 1913.

THE STATE OF TEXAS, 1913.

THE STATE OF TEXAS, 1913.

THE STATE OF TEXAS, 1913.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV. 68

| | | | | | | |
|--|--|--|------------------------------------|--|--|--|
| 07432 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07425 | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
| SHELTON | | L | | WHARTON | MAY 30 69 | 8:15 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR |
| MALE | | NEGRO | | Aug. 10 th 1927 | 24 YRS. | MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | |
| Maryland | | USA | | | PRINCE GEORGE Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| ANDREWS AFB | | MALCOLM GROW USAFHOSP | | AIR FORCE | | AIR FORCE |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| MARYLAND | | PRINCE GEORGE'S | | ANDREWS AFB | 3776-7 LOUISIANA DRIVE | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| Unknown | | | | | Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| YES | | 218-20-3096 | | Lillian Wharton same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION WITH CHF AND | | | | | | 12 HRS |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (b) SHOCK | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | |
| (c) CORONARY ARTERY DISEASE | | | | | | 5 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 29 May, 1969, to 30 May, 1969, that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) found the deceased alive on 30 May, 1969, and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | |
| David Rosenthal | | | | 30 May 69 | | |
| 22d. PHYSICIAN'S NAME (Type or print) | | | | 22e. ADDRESS | | |
| DAVID ROSENTHAL MAJ USAF MC | | | | MALCOLM GROW USAF HOSP ANDREWS AFB | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 6-7-69 | Mt. Zion Cemetery | | Snow Hill Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| W. W. Chambers Co. 517-1111 | | | | DATE JUN 9 1969 | | W. W. Chambers Co. |

03433

31:13 89 30 MAY WHARTON L SHELTON

MAIL NEGRO

PRINCE GEORGE USA Maryland

AIR FORCE MALCOLM BROWN USAF0809 AIR FORCE ANDREWS AFB

STIC-7 LUGBATA BRIN AIR FORCE TROOP 13 AIRBORNE AFB

YIP 81-30-000

ACUTE MYOCARDIAL INFARCTION WITH CHF AND 10 HRS

SHOCK

CORONARY ARTERY DISEASE 2 YEARS

29 May 89 30 May 89 31 May 89

29 May 89 30 May 89

X 30 May 89

DAVID ROSENTHAL MAL USAF MC MALCOLM BROWN USAF 8098 ANDREWS AFB

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|--|-----------------------|---|------------------------|--|--|
| <div> <div>07433</div> <div>07426</div> </div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR |
| Nellie | | | C. R. | | | Wike | | | 1:05 am |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED OEO | | | 2d. HOUR |
| Female | W | 23 JULY-25 43 | YRS. | MONTHS | DAYS | Month 5 Day 1 Year 19 69 | | | 1:05 a. M. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Prince George | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | |
| Virginia | | | Henry | | Bassett | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Rt. 3 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Elige | | | RAKES | | | Gladys Blevins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 228 28 0308 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Shock | | | | | | | | | |
| 8121 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) Burns 3rd degree 50% of body surface | | | | | | | | | 13 hrs |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONOITION GIVEN IN PART I(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | 9:00am 4-30-69 | | Passenger in truck involved in collision | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | Street | | Rt 495 at Rt 214, Prince George Co., | | | | MD. | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | | | | |
| John Kehoe, N.D., Riverdale, Md. | | | ADDRESS (Street, city, town, or county) | | | 501069 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. OATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| Burial | | 5/5/1969 | | Henry Memorial Gardens Com. | | Bassett | | Henry | Virginia |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NALLEYS FUNERAL HOME | | | | MAY 5 1969 | | J. Charles Judge | | | |

07433

UNITED STATES DEPARTMENT OF THE ARMY

2-4-

100-100000

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE BUREAU OF MILITARY HISTORY
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]

4. [Illegible]
5. [Illegible]
6. [Illegible]

7. [Illegible]
8. [Illegible]
9. [Illegible]

10. [Illegible]
11. [Illegible]
12. [Illegible]

13. [Illegible]
14. [Illegible]
15. [Illegible]

16. [Illegible]
17. [Illegible]
18. [Illegible]

19. [Illegible]
20. [Illegible]
21. [Illegible]

22. [Illegible]
23. [Illegible]
24. [Illegible]

25. [Illegible]
26. [Illegible]
27. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
45M - 1-69

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 14 | | 07434 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07427 | |
| 1. DECEASED-NAME
(Type or print) <i>Ethel G. Wilson</i> | | | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>7</i> Year <i>1969</i> | | 2b. HOUR
<i>10:30</i> M | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Negro</i> | | 5. DATE OF BIRTH
<i>Sept. 13, 1893</i> | | 6. AGE (In years lost birthday)
<i>75</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Wash. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Prince Georges</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Clinton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Pine View Gardens</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>D.C.</i> | | 13b. COUNTY
<i>Washington</i> | | 13c. CITY OR TOWN
<i>Washington</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1526-83 St. N.W. Wash. D.C.</i> | |
| 14. FATHER'S NAME
First <i>Joseph</i> Middle <i>Garnett</i> Last <i>Harriett</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Harriett</i> Middle <i>J. Cleveland</i> Last <i>J. Cleveland</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
<i>578-30-3243</i> | | 17. INFORMANT
<i>Mr. Ivano Garnett</i> | | Address
<i>1002 Douglas St. N.E. Wash. D.C.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary occlusion</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cerebrovascular sclerosis of the vessels.</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4109</i>
<i>1/2 hr.</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>decubiti sacral area and anoxemia</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-17, 1969</i> , to <i>4-7, 1969</i> , that (I) (we) lost saw the deceased alive on <i>4-7, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Alfred R. Lapin</i> | | 22c. DATE SIGNED
<i>4/7/69</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>ALFRED R. LAPIN MD</i> | | | | | |
| 22e. ADDRESS
<i>CLINTON, MD</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>5-12-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lincoln Memorial Suitland - Md</i> | | 23d. LOCATION (City or Town) (County) (State) | | | |
| 24. FUNERAL DIRECTOR
<i>William Spangler</i> | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | 25c. MAY 12 1969 | | | |

07432

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1917

Dear Sir:

I have the honor to acknowledge the receipt of your letter of January 31, 1917, regarding the matter mentioned therein.

The same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,

W. B. HARRIS
Secretary

Very truly yours,
W. B. HARRIS
Secretary

UNITED STATES DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07435

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07428

| | | | | | | | | | |
|--|--|---|--------|---|---|--|---|---|------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| Herman | | | | Windsor | May 10 1969 | | 9:20 AM | | |
| 3. SEX
Male | | 4. RACE
colored | | 5. DATE OF BIRTH
03-01-15 | | 6. AGE (In years
last birthday)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
Prince Geo's Co | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Upper Marlboro | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
Clarence Windsor | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME
Ida Estelle Harper | | First | Middle | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Marion Spencer Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) massive pulmonary edema
514x DUE TO, OR AS A CONSEQUENCE OF cardiac failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from 04-10-69, 1969, to 5-10-69, 1969, that (H) (we) last saw the deceased alive on 5-10-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dr. Longoria / Teledina | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S
NAME (Type) Dr. Ricardo Longoria M.D. | | | | | 22e. ADDRESS
6001 Landover Rd. Cheverly, Md. | | | | |
| 23a. BURIAL CREMATION
REMOVAL (Specify) | | 23b. DATE
May 15/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Brooks Ch. Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Nottingham P. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
Martell Adams | | | | ADDRESS
Crownsville, Md. | | 25a. REC'D BY REGISTRAR
DATE
21 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01437

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07436

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07429

| | | | | | | | | |
|--|------------------------------|---|--|---|-------------------------------------|---|---|----------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | |
| Howard | | B. | Windsor | | Month
May 7 Day
1969 | | 4 A M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birth day) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | White | | 07-28-1900 | | 68 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | U. S. A. | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Cheverly | | Prince George's Gen. Hosp. | | Plumber | | Plumbing | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| MD | | Prince George's | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 9920 Franklin Ave. East | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle |
| Eugene | | | | Windsor | Frances | | | Ferguson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| Yes | | WW 11 | | Frank E. Gasch | | 4002 48th Street
Bladensburg, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>chronic pulmonary disease</u>
5192 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>and Duodenal ulcer - bleeding</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 4-21-69 | | massive GI bleed | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that XX (this hospital) attended the deceased from April 19, 1969, to May 7, 1969, that XX (we) last saw the deceased alive on May 7, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>A. S. Banisar M.D.</u> | | | | DEGREE ATTENDING
PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-7-69 | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | 22e. ADDRESS | | | | |
| A. S. Banisar, M.D. | | | | 6323 Landover Rd. Cheverly, MD. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 5/10/69 | | Cedar Hill | | Suitland P. G. Md. | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | |
| Francis Gasch's Sons | | | | Hvattsville, Maryland | | DATE MAY 9 1969 | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 FILLING 5/29/69 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07437

07430

| | | | | | | | | |
|---|-------------------------|--|---|---|---|---|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) Ifene M. Witherspoon | | | 2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> May 16 1969 | | | 2b. HOUR <input type="checkbox"/> 6:00 P.M. | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
8-9-05 | 6. AGE (In years last birthday)
63 YRS. | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD
Month 5 Day 16 Year 1969 | | |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Prince George's Md. | | |
| 10. CITY OR TOWN OF DEATH
Oxon Hill | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
5200 Westfield Drive | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Held-Kiplinger News Agency | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Prince Geo. | | | 13c. CITY OR TOWN Oxon Hill | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME
Zachary T. Miller | | | 15. MOTHER'S MAIDEN NAME
Jennie Aulthouse | | | 13e. STREET AND NUMBER
5200 Westfield Drive | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | | 16b. SOCIAL SECURITY NO.
579 01 0936 | | 17. INFORMANT
John S. Witherspoon | | | ADDRESS Oxon Hill, Md |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4122 IMMEDIATE CAUSE (a) Pulmonary edema and congestion
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertensive cardiovascular disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Victor A. Fazekas, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
5-17-69 | | |
| EXAMINER'S NAME (Type)
Victor A. Fazekas, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) Prince Geo. Gen. Hosp | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-19-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Md. | | |
| 24. FUNERAL DIRECTOR
Simmons Bros | | | | ADDRESS
1661 Good Hope Rd SE Wash DC | | 25a. REC'D BY REGISTRAR
MAY 19 1969 | | 25b. REGISTRAR'S SIGNATURE
V. Charles J. J... |

07437

Medical Examination - Certificate of Death

| | | | | | | | | | |
|------------------------|--|----------------------|--|----------------------|--|----------------------|--|------------------------|--|
| Name | | Age | | Sex | | Race | | Date | |
| John Doe | | 45 | | Male | | White | | 10-15-1918 | |
| Address | | City | | State | | County | | Zip | |
| 123 Main St | | New York | | NY | | New York | | 10001 | |
| Occupation | | Education | | Marital Status | | Religion | | Previous Illnesses | |
| Teacher | | High School | | Married | | Catholic | | None | |
| Cause of Death | | Manner of Death | | Place of Death | | Time of Death | | Signature of Physician | |
| Heart Failure | | Natural | | Home | | 10:00 PM | | [Signature] | |
| Medical History | | Family History | | Social History | | Autopsy | | Remarks | |
| Hypertension | | None | | None | | No | | None | |
| Medication | | Diet | | Smoking | | Alcohol | | Other | |
| None | | Normal | | None | | None | | None | |
| Physician | | Hospital | | Nurse | | Pathologist | | Coroner | |
| Dr. Smith | | St. Mary's | | Mrs. Jones | | Dr. Brown | | Mr. White | |
| Signature of Physician | | Signature of Coroner | | Signature of Witness | | Signature of Witness | | Signature of Witness | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

5718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07438

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08921

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Carrie L. Yates | | | 2a. DATE OF DEATH
Month May Day 21 Year 69 | | | 2b. HOUR
10 P M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
2 May 1892 | | 6. AGE (In years lost birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Pr. Geo. Co. Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Adelphia, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Manor Care Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY
Pr. Geo. Co. | | 13c. CITY OR TOWN
Suitland, Md. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3303 Terrace Dr. | |
| 14. FATHER'S NAME First Middle Lost
James Dingee | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
Henrietta Chesildine | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Olive L. Wortz-daughter Same as #13d | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Swai Jarlue
5718 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Coronary
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-14-69 , 19__, to 5-21-69 , 19__, that (I) (we) last saw the deceased alive on 5-19-69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Dr. Allan Cohan | | | | | 22c. DATE SIGNED
6/12/69 | | 22d. PHYSICIAN'S NAME (Type)
Dr. Allan Cohan | | | |
| 22e. ADDRESS
13515 Ga. Ave Silver Spring, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5/24/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor, Md. | | | | |
| 24. FUNERAL DIRECTOR
Lee Funeral Home 300-4th St. N.E. Wash. D.C. | | | | | 25a. REC'D BY REGISTRAR
JUN 13 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

185X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07439

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07431

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) <i>Lloyd</i> First <i>Young</i> Middle <i>Young</i> Last | | 2a. DATE OF DEATH
Month <i>5</i> - Day <i>17</i> - Year <i>1969</i> | | 2b. HOUR
M | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>Col.</i> | 5. DATE OF BIRTH
<i>6-9-1910</i> | 6. AGE (In years
In () Day () YRS. <i>58</i> | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) <i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Prince George</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Chesley</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Prince George</i> | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Farming</i> | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md.</i> | 13b. COUNTY
<i>Prince George</i> | 13c. CITY OR TOWN
<i>Upper Marlboro</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>R. 2 - Box 119</i> | |
| 14. FATHER'S NAME First <i>Earnest</i> Middle <i>Young</i> Last <i>Young</i> | 15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Taylor</i> Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <i>No</i> (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.
<i>21326863</i> | 17. INFORMANT Address
<i>Ethel Savoy Upper Marlboro Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac & Respiratory arrest</i>
<i>185X</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Malignant Ca of Prostate gl.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Anemia 27 to Malignancy</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last
saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Thipavan Tharuday</i> | | DEGREE
ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED
<i>5-17-69</i> | | |
| 22d. PHYSICIAN'S
NAME (Type) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | 23b. DATE
<i>5-21-1969</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Brewer Hill</i> | 23d. LOCATION (City or Town)
<i>Annapolis</i> (County) (State) | | |
| 24. FUNERAL DIRECTOR
<i>Robert Bennett</i> | | ADDRESS
<i>Home Annapolis</i> | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 20 1969</i> | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

07433

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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